University of Alberta

The Process of Creating a Healthy Community in Rural Alberta

by

Brett A. Hodson ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment

of the

requirements for the degree of Master of Science

Centre for Health Promotion Studies

Edmonton, Alberta

Spring, 1999

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Abstract

Process evaluation research has been identified as potential content foci for knowledge development in the field of health promotion, and more specifically in Healthy Community projects. Using an ethnographic research design to gather and analyze data from 18 members of a community health coalition using in-depth interviews, and 11 coalition meetings using participant-observation techniques, the process of creating a healthy community was explored and described. Study findings suggest that the process is dependent upon both the framework and functional aspects of the coalition. The framework includes the coalition's purpose, as well as the criteria and characteristics of its membership, while the functional aspects include need identification, decision-making, action and mobilization, evaluation, and sustainability. Implications for health promotion practice and future research include, but are not limited to, development of a greater understanding of organizational processes, assessment and evaluation tools, and healthy public policy, all in the community health promotion context.

Acknowledgement

I gratefully acknowledge the assistance of the following people for their contribution to this work:

First, Dr. Kim Raine-Travers for her interest in this topic, her willingness to accept the challenge of working with me from a distance, and most importantly her prudent guidance which somehow supported me while giving me ownership over the process.

Second, to Dr. Wilfreda (Billie) E. Thurston for her willingness to collaborate on this project, and for providing insight and critical praise that assisted in making this thesis a success.

Third, to Dr. Herb Northcott for his positive influence, professional editing skills, and constructive criticism.

I would also like to thank:

The staff of the University of Alberta Centre of Health Promotion Studies for their support and encouragement during my course and thesis work.

All the research participants for their time, effort, interest and providing the opportunity to collect the necessary data for without this project could not have been completed.

Most importantly I would like to thank my parents who provided me the tools to undertake and complete such a project, and my wife Candie, who accepted that I would not be satisfied without this achievement and encouraged me to do my best. Her love, caring, and support helped me through my educational pursuits, and will always serve as a reminder that anything is possible if one puts his or her mind to it.

Production of this document has been made possible by a financial contribution from the Health Transition Fund, Health Canada, and the support of Alberta Health. The views expressed herein do not necessarily represent the official policy of Health Canada

Thank you.

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Chapter 1

Introduction

Despite the enormous allocation and utilization of resources by health care institutions, medical services are only able to achieve so much in terms of improving the health status of individuals and communities (Calgary Regional Health Authority, 1999). In addition, with the increasing acceptance that individuals and groups are better able to influence the factors that affect their health given the skills, resources, and a supportive environment necessary to do so, there has been a resurgence toward the models and values of health promotion (Raeburn & Rootman, 1998). Furthering the advancement of this rekindling, the ideas of how health is determined have been augmented beyond the previous beliefs of individual behavior and genetics, or the absence of illness and disease, to include the social and physical environment created and manipulated by the very people that interact and live within it (Collins, 1995). Moreover, the definition of health itself has expanded beyond the medical model, and is now heeded as a resource for everyday living (WHO, 1986), and a foundation for achievement (Seedhouse, 1986).

Much of the foundation of health promotion theory and practice is based upon concepts that have both functional (process) and instrumental (outcome) elements (Rootman & Goodstadt, 1996). At the forefront of these concepts and practice is empowerment and community development (Brown, 1991; Raeburn & Rootman, 1998; Schulz, Israel, Zimmerman & Checkoway, 1995). Empowerment theories in health stem from the belief that there is a discrepancy in society between groups that have power and control over resources and those that do not (Gutierrez, 1990), and that a redistribution of power and resources will result in improved health status (Wallerstein, 1992).

Community development is an approach taken by health professionals to facilitate a collaborative process between stakeholders, and based upon the belief that all community members, including government institutions and private corporations, should have the opportunity to participate when it comes to identifying health issues, and planning, implementing, and evaluating the solutions to those issues (Brown, 1991; Labonté, 1993a).

Although 'community' is a somewhat ambiguous term, it is generally agreed that it represents a group of individuals sharing experiences that may or may not be geographically bound (Israel, Schulz, Zimmerman, & Checkoway, 1994), and deemed an essential part of every health program (Labonté, 1989). Communities are viewed as the 'target' of broad based health promotion strategies geared toward reducing risk factors within the social and physical environment (Labonté, 1992 as cited in Baum & Sanders, 1995; Guldan, 1996; Petersen, 1994), and often the unit of analysis for health promotion research (Hamilton & Bhatti, 1996; Health Promotion Development Division, 1996). However, despite the complexity of such health related issues it is believed that the people in communities have the knowledge to, and are decidedly capable of, making the decisions and taking the appropriate actions to improve health status (British Columbia Ministry of Health, 1989).

Small groups, organized from within the community to address health issues, have been identified as the medium for change directed toward improving health (Labonté, 1993b). These groups are affected by member, structural, environmental and developmental factors that determine how the group functions and its influences on specific outcomes (Northouse & Northouse, 1992). Further, the method of how change is

achieved is dependent upon the specific values and principles that the group adopts and adheres to, usually reflected by the individuals that form the group (Kiesler, 1978; Tubbs, 1984). The small group organized under the presumption of empowerment and community development is subject to democratic processes that reflect equality in all aspects of group formation and functioning (British Columbia Ministry of Health, 1989; Gastil, 1993; Labonté, 1993b).

The Healthy Communities movement, established in 1986, is a community development initiative that is designed to facilitate the process of developing capacity in communities with the intention of improving health status (Baum, 1993; Hancock, 1993a; Flynn, 1992; Poland, 1996a). Capacity is defined as knowledge and skills required for all individuals and groups, professional and non-professional, to work together at the community level to improve health (Hall & Best, 1997). Further, consistent with the concepts of health promotion, empowerment, and community development, communities undergoing the Healthy Community process encourage participation by developing their own meaning of health, establish intersectoral partnerships, and design and implement their own methods and strategies to reach that end (Hayes & Willms, 1990).

Healthy Community projects are characterized by a multisectoral approach to the formation of a coalition that includes local government, businesses, non-government/community agencies, and individual community members with the common purpose of improving the health of the community (Hancock, 1995). These coalitions are subject to the same development issues that any group is faced with in such a partnership, including the characteristics of membership, communication, and operational processes (Scott & Thurston, 1997).

The emphasis on the functional aspects of health promotion, empowerment, community development, and the small group, particularly within the healthy communities context, makes these subject areas particularly amendable to process evaluation research. Process evaluation, the determination of how certain outcomes have resulted from specific activities or methods (Dehar, Casswell, & Duignan, 1993), is important in determining if, amongst other things, a program has been implement as intended, as well as understanding and framing the outcomes of health promotion interventions (McGraw et al., 1989). Moreover, process evaluation research has been cited as potential content foci for knowledge development of Healthy Communities projects in general (Poland, 1996a). The information resulting from such evaluation research will assist in the development of a conceptual understanding of empowerment, community development, and group process theories applied in the healthy community context, and may be used practically, in a formative sense, to improve existing and future healthy community projects currently being implemented.

Purpose of the Study

Therefore, based upon the relevant conceptual and theoretical underpinnings that constitute the Healthy Communities movement, the purpose of this study is to explore, describe, and evaluate the process of creating a healthy community.

Chapter 2

Review of Literature

Concepts and literature important to the process of creating healthier communities will be investigated and reviewed. These concepts are not mutually exclusive and relate to each other both directly and indirectly when applied to strategies that have the goal of improving health status in community settings. Specifically, concepts including health promotion, empowerment, the meaning of community and community development, small groups and group process, the healthy cities/communities movement and health coalitions will be reviewed to develop a theoretical base of information that link these concepts together.

Health Promotion

Health promotion is a concept with the semblance of both process and outcome (Rootman & Goodstadt, 1996). Definitions of health promotion orientated toward process reflect the underlying mechanisms by which the instrumental and ultimate outcomes are reached. A thorough review of various health promotion definitions has been completed elsewhere (Rootman & Goodstadt, 1996). This examination of the term health promotion will introduce some of the findings of that review, and consider other literature on the subject.

In 1986, the World Health Organization (WHO) defined health promotion in what is now considered the landmark document, the Ottawa Charter for Health Promotion, as "the process of enabling people to increase control over, and to improve, their health" (p. 1). Further, in their quest to achieve health, individuals or groups must also be able to identify and realize aspirations, satisfy needs, and change or cope with the environment.

The principal strategies outlined in the charter for promoting health include developing healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and the reorientation of health services through intersectoral collaboration and partnerships between agencies, as well as political, institutional, and grass roots organizations and individuals from within the community. Although the Ottawa Charter (WHO, 1986) was not the first to acknowledge the contributions of the social, political, and physical environment and their effects on health, it marked an international resurgence of ideals and practices toward a broader view of how health is achieved (Rootman & Goodstadt, 1996).

Since this reawakening, other definitions of health promotion have been introduced to challenge and improve upon the one released in the Ottawa Charter (WHO, 1986). For instance, Stachtchenko and Jenicek (1990) replaced "people" in the Ottawa Charter (WHO, 1986, p.1) definition of health promotion with "individuals and communities" (p.54) to make it clear that both individuals and communities can increase control over "the determinants of health" (p. 54), also added to clarify what specifically needed increased control to improve health status.

The determinants of health are social, environmental, and individual in nature. Most recently in Canada, the determinants of health have been reported to include living and working conditions, the physical environment, biology and genetic endowment, personal health practices and coping skills, and health services (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1996). Each determinant identifies factors that may be manipulated to benefit individuals directly, or change the social structure as a whole to benefit all in society. Each has a set of challenges that

require specific and equal attention to improve the health of Canadians. Each determinant is interrelated through a complex web of political ideologies (such as capitalism), individual rights (democracy), and individual capacity (biology and genetics).

Definitions of health promotion have also focused on lifestyle behaviors. For example, health promotion has been described as "the science and art of helping people change their lifestyle toward a state of optimal health" (O'Donnell, 1986, p. 4). This description of health promotion received a great amount of attention due to its focus on behavior, and was amended to place a greater emphasis upon the importance of the influence of the environment upon the shaping and adoption of healthy behaviors (O'Donnell, 1989). Often victim-blaming, or neglecting the effects of the social and physical environment on people's abilities to make decisions, results from an over emphasis on specific unhealthy behaviors rather than on the predisposing factors affecting these behaviors (Birch & Stoddart, 1989).

Health promotion has also been viewed as comprised of the overlapping spheres of health education, prevention, and protection, with the goal of enhancing positive health and reducing the risk of ill health (Downie, Tannahill & Tannahill, 1996). Health education is defined as communication intended to influence the beliefs, attitudes, and behaviors of individual and groups to improve health status. Prevention strategies include those that reduce the risk of occurrence of disease, illness, injury, disability, and handicap. While protection, on the other hand, is characterized by regulatory action including fiscal and legal controls, voluntary codes of practice, and policies that reduce social and physical environmental hazards, and increase the opportunity to live in an

environment that promotes health. This interpretation of health promotion is consistent with that of the Ottawa Charter, however goes further by setting out specific categories as scopes of practice for individuals, groups, and agencies as health promoters (Downie et al., 1996).

A seemingly simple, but very broad, definition of health promotion combines education and environmental supports that facilitate actions and conditions of living contributory to health (Green & Kreuter, 1991). In this case, the "actions and conditions" (p. 4) refer to those taken and created by individuals, groups, and communities in general, and more specifically, policy makers, employers, teachers or others who directly influence or control the determinants of health. In addition, individuals have the ability to control those issues that fall within the personal realm, however with the increasing complexity of social issues, communities are better equipped to effectively make decisions and take action to improve health status.

Another somewhat general, but deliberate, portrayal of health promotion incorporates any activity that has the intention of improving the physical and social environment so that a person's well-being is increased (Labonté (1992) as cited in Rootman & Goodstadt, 1996). This definition does not discriminate between the ability of specific disciplines or programs to promote health, and as such there is a distinct risk of health promotion becoming anything to anybody (Baum, 1993). Albeit, this risk is not particularly dangerous in and of itself, it does pose a conceptual and theoretical challenge to those in the health promotion discipline when they are attempting to define their roles in the health field as practitioners. However, this challenge may in fact make this simple definition one of the most appropriate. With the emphasis upon individuals and

communities taking control to influence the determinants of health, the role of the health promotion practitioner may be limited to a resource that facilitates the process, and as an advocate for healthy public policy, rather than a role that directs activity and limits opportunities for the actualization of control.

Despite the divergence in perspective and emphasis reflected in the definitions of health promotion above, there are fundamental and substantial commonalties among them all (Rootman & Goodstadt, 1996). Principal features include the broadening of the definition of health and the determinants of health, and moving beyond individual behavior and lifestyle initiatives to consider social and political strategies to achieve health (Robertson & Minkler, 1994). Moreover, the acceptance of the concept of empowerment as a key health promotion strategy (discussed below), advocating for the participation of the community in identifying health related issues, and developing and implementing solutions to those problems also symbolizes prevailing aspects of health promotion practice (Robertson & Minkler, 1994). These commonalties represent a diverse set of actions that are focused on individuals and communities, and directed toward improving health status (Rootman & Goodstadt, 1996).

Therefore, the importance of health promotion as a legitimate process for improving the health of individuals and communities is both categorical and inferred. Thus, it is important that the integrity of the initiatives named under the umbrella of health promotion be explored, described, and evaluated specifically to determine the value and significance of such programs pointed at improving health status of individuals, and the community at large.

Empowerment

Empowerment, often equated with health promotion, has been connoted implicitly in the various definitions of health promotion presented above. The "cardinal principle of health promotion" (Downie et al., 1996, p. 60) has, in fact, been described as empowerment, a claim that has been substantiated elsewhere (Labonté, 1993b; Rissel, 1994; Robertson & Minkler, 1994; Rootman & Goodstadt, 1996). To better understand the concept of empowerment in relation to health promotion, the association between power and health requires closer examination.

"Power is the ability to predict, control, and participate in one's environment" (Robertson & Minkler, 1994, p. 298). Power may be considered a resource, which is acquired through education, occupational position, or income, all of which represent a form of higher social status. Access to determinants of power, such as a high level of education or income, provide opportunities to effectively use, or gain other resources ultimately to direct and regulate activities and people. Further, a relative lack of power, or powerlessness, may be attributed to several social risk factors and include, amongst other things, living in poverty, placement low in the social hierarchy, and a lack of social support, all of which are postulated to result in a lack of control over destiny and ultimately disease (Wallerstein, 1992).

More specifically, a lack of control resulting from little or no power affects health and well-being through the stress process (Israel et al., 1994). The relative lack of control a community or individual experiences results in distress causing both negative short term responses and long term negative outcomes. Further, there is a direct relationship and a mediating effect of resources and conditioning variables at the social,

psychological, biophysical, and genetic levels upon the stressor, distress, and the short and long-term effects of the distress on communities and individuals. These mediating factors may act to limit or accentuate the negative outcomes of the distress, or eliminate the capacity of the stressor directly. Health promotion initiatives are often directed at improving resources and conditioning variables in order to reduce the intensity of the stressor directly, or lessen the effects of the short and long term distress and its effects in order to improve health status.

In some social circles power is considered to be a "zero-sum commodity"(Rissel, 1994, p. 40), where a gain in power for one group requires and results in a loss for another. In this context resources are hoarded by those in control to maintain status, motivated by greed and actively oppressing those with limited and few resources to prevent the 'have nots' from obtaining power. Those in a position to use power (control) do so by using it overtly or coercively to actively suppress, subtly to defuse through negotiation, compromise, or co-optation, and covertly by purposefully ignoring alternatives (Lukes, 1974 as cited in Eakin, Robertson, Poland, Coburn, & Edwards, 1996). Alternatively, power is also considered by some to be boundless, unlimited, and available to any and all that wish to have it as long as there is a process that accommodates equal access to resources, free of political posturing and fostering social justice (Dorr, 1991; Swift & Levine, 1987). However, it has also been argued that established groups and power structures will be unwilling to forgo control of resources without some degree of conflict (Baum, 1990).

Empowerment then, considered in a broad sense similar to that of health promotion represents both an outcome and a process (Drevdahl, 1995). As an outcome,

empowerment is the absence of alienation, learned helplessness, and victim blaming (McKnight, 1985; Wallerstein, 1992), or the increased possibility for people to control their own lives and make choices, realize improved access to resources, self-esteem, and cultural identity (Labonté, 1993b; Rappaport, 1981; Robertson & Minkler, 1994). Alternatively, empowerment is a social action process that promotes participation of people, organizations, and communities towards the goal of individual and community control, political efficacy, improved quality of community life, and social justice (Wallerstein, 1992). To many, health promotion and empowerment is taking action as individuals and collectively to assert personal control over their own lives. This includes altering their own behavior and changing their immediate conditions, and influencing factors that are beyond individual control and more effectively addressed as a group (Brown, 1991).

Empowerment, as both outcome and process, is recognized at a minimum of three levels: individual, organizational, and community (Israel, et al., 1994; Robertson & Minkler, 1994). Further, in a review of literature by Rissel (1994) of the contribution of conceptual and theoretical applications of empowerment to health promotion, it has been acknowledged that there is a distinction between the subjective experience and objective reality of empowerment (Swift & Levine, 1987) separated by feelings and perceptions and actual redistribution of resources and decision-making power (Rissel, 1994).

Individual, or psychological empowerment, is characterized by an individual's sense of greater control over his or her own life following active membership in groups or organizations, with desire to, but not necessarily the result of, participation in collective political action in the public domain (Rissel, 1994; Zimmerman & Rapport,

1988). Psychological empowerment has been further compared to Bandura's (1982) theory of self-efficacy as it relates to competence, mastery and control (Israel et al., 1994), and the process of participation to influence institutions and decisions (Zimmerman, 1990). This is analogous to empowerment at the intrapersonal level where an individual has a potent sense of self, enhanced self-esteem and self-efficacy, and the ability to make choices (Shah, 1990 as cited in Labonté, 1993a). It is noted however, that within these definitions of psychological empowerment, there is no mention of any actual reallocation of resources or decision-making power, only an increase in an individual's perception of influence and control resulting from acting as an individual and within the context of a group.

At the organizational level, a democratic process reflects empowerment when members of an organization share information, power, and control over all aspects of the organization's activities in pursuit of a common goal (Israel et al., 1994). Further, an empowered organization has the ability to influence the larger system it is a part of by affecting policies and decisions in the community (Israel et al., 1994). The notion of empowerment at the organizational level is further reflected in democratic and feminist processes characterized by mutual respect where decision-making power is shared among all of the members of an organization (Gastil, 1993; Wheeler & Chin, 1991).

Empowerment at the community level most closely resembles health promotion defined in the Ottawa Charter (WHO, 1986), specifically as empowerment relates to the ability of individuals and organizations to act as a community to address conflicts, provide support, and influence and control issues that affect the quality of life (Israel et al., 1994). Here again the dual nature of empowerment as both outcome and process is

validated. The "ability" (p. 153) (outcome), to "address" (p. 153) (process) are inextricably linked in order for a community to have influence and control, and essentially gain power to influence life circumstances. Additionally, community empowerment is characterized by an over all increase in psychological empowerment among the community's members following participation in collective political action, resulting in the somewhat objective measure of an equitable redistribution of resources (Rissel, 1994). The process of conscientization, the realization of the social, political, and economic contradictions that oppress and control, results from critical thinking and a awareness of shared experiences between community members, and facilitates the movement from psychological to community empowerment (Friere, 1970; Wallerstein, 1992). This mirrors the process of empowerment at the intergroup level as greater social equity and strategies for sociopolitical gains are cultivated through participatory democracy and advocacy (Shah, 1990 as cited in Labonté, 1993a). These views of community empowerment are more outcome based, however these outcomes are dependent upon the processes that contribute to the psychological sense of empowerment, and participation in a group setting (Rissel, 1994).

However, the consanguinity between empowerment and health promotion has been reviewed critically as equivocal (Grace, 1991; Guldan, 1996). Specifically, the lack of empirical scientific evidence to support empowering strategies that improve health, the "consumerism" of empowerment in health promotion limiting its practicality and applicability to the field, and the discourse of health professionals, similar to that of marketing and management, is one of control over the empowerment process. For example, health promotion practitioners typically do survey and other research to

determine the 'needs' of the community, and apply pre-packaged models and theories to fulfill those needs (Grace, 1991). This is related negatively to a market model of creating consumer needs and demands, and producing goods and services to fulfill those demands (Grace, 1991).

The use of the term empowerment in relation to the health 'professional' and the 'client' has also been critically reviewed (Labonté, 1993b). Health promotion practitioners are warned about using and acting out the process of empowerment in a transitive fashion. As a person in a position of power, the health promoter must be careful not to take the role of the "empowering agent" (p. 51), and remain a "controlling actor" (p. 51) with ability to bestow power on others. On the other hand, when empowerment is used intransitively, the role of the health promoter is as a resource and assists in constructing a supportive environment to ensure the client/community can realize the acquisition or redistribution of power.

These arguments reiterate the importance of determining the level of fidelity with which health promotion programs have been implemented, particularly when they are intended to increase the amount of power and control at the individual, organization, and community levels. More specifically, if health promotion, and particularly empowerment, are considered to be processes intended to increase the capacity and ability of individuals, organizations, and communities to influence their physical and social environment with ultimate outcome of improving health, these programs should adhere to the principles and values that underlie these processes. Moreover, investigations that evaluate these processes should consider the context in which they take place, in this case the community.

Community and Community Development

Community has been used throughout this review without any formal definition or examination of what the term represents. In order to frame health promotion and empowerment at the community level, an understanding of what community is, or has been defined as, is required. Again, like health promotion and empowerment, many definitions of community exist, varying in complexity and inclusiveness.

At the most simple level a community is a population (Hawe, 1994). Taken one step further, a community represents "an aggregation of individuals with some shared experience" (Collins, 1995, p. 320). This basic and broad definition may refer to a group bounded geographically, culturally, or socially allowing the application of the term community to be as all-inclusive as possible. However, the community concept is not simple, and instead is rather complex (Labonté, 1993b). For instance, a community is a group of persons with a shared identity as group members and a sense of collective purpose that may not be based in the same locality (Labonté, 1993b). Further, communities are generally made up of different, but equally important sub-communities, each with their own beliefs and values that require a varied approach to health promotion (Guldan, 1996, Labonté, 1993a).

A composite interpretation of community drawing on the terminology of several definitions, and consolidating many of the concepts found elsewhere expresses community has having the elements of: 1) membership; 2) common symbol systems (such as language); 3) shared values and norms; 4) mutual influence (between members); 5) shared needs and commitment to meeting them; and 6) shared emotional support (Israel et al., 1994). Reiterating Labonté (1993a), a community in this definition may be

geographically bounded, but not necessarily. Alternatively, an urban population or centre may be a group of unconnected people and have little sense of communality (Israel et al., 1994).

How do health professionals reach the community to improve health status? The answer lies in what is known in the health and social fields as community development. Community development is the process by which health professionals organize and support community groups to identify health related issues, plan and implement strategies that alter the social environment, and increase a community group's capacity and decision-making power (City of Toronto as cited in Labonté, 1993a). Further, community development reinforces the everyday aspects of life, culture, and political activities that contribute to health (Canadian Public Health Association as cited in Chalmers & Bramadat, 1996).

Community development as a viable health promotion strategy hinges upon successful community organization and participation (Petersen, 1994), also referred to as community activation or action (Brown, 1991; Labonté, 1993b, Wickizer, et al., 1993). Community organization is the result of the deliberate formation of temporary or permanent structures that involve individual members of the community in order to form healthy public policy, or alter the social or physical environment in order to improve health status (Brown, 1991). Further, community organization describes the process of organizing people around health related issues larger than group members' own immediate concerns (Labonté, 1993b).

An important distinction needs to be made between community development as a health promotion strategy and community-based programming (Labonté, 1993a, 1993b).

In community-based programming health issues are defined, and strategies to address these issues are developed and implemented by health professionals, rather than by a community collaborating with a professional. The intended outcomes of the professionally developed and implemented programs are changes in behavior or the specific problem, rather than an overall increase in the community's capacity. The level of participation of community members in the change process primarily distinguishes the differences between community development and community-based programs. The various degrees of participation of community members in health promotion programs are delineated as professionally or locality dominated, where one group dictates to the other, or through negotiated equity (Labonté, 1993b) resulting in shared accountability between community and health professional. Participation by the community at large in health promotion-empowerment-community development strategies is characterized by shared decision-making authority, formalized relationships between members, stakeholder legitimacy and accountability, and equal resource allocation to ensure stakeholder participation is viable (Labonté, 1993b).

These are similar issues to those of empowerment and the role of health professionals in empowerment-based interventions, as they have been discussed above. For instance, although community development strategies often claim that control of the program belongs in the hands of the people, some programs are still "expert-driven" (Guldan, 1996, p. 693), and professionals are expected to develop, plan, implement, and evaluate these "deprofessionalized, community-based" programs (Grace, 1991, p. 331) that "have not challenged established power relations" (Petersen, 1994, p. 215). Further, those in authority may simply be manufacturing and pre-modeling an environment that

only provides an opportunity for "pseudo-participation", and instead controls people's behaviors (Grace, 1991, p. 333). Moreover, health professionals are often regarded as "knowers and experts" (Drevdahl, 1995, p. 21), while everyone else are just "disempowered others" (p. 21).

Here again, the relative importance of ensuring a community development program, as one method of promoting health, has been implemented as intended is demonstrated. Emphasis on describing a process of this kind in relation to the principles and values of health promotion and empowerment is important to determine if such a project may, in fact, be considered to be 'community development' as it has been described above. Further, such an investigation should consider the specific context in which the process is occurring, with specific attention being paid to the role of the 'professional' in relation to the 'client community'.

Communities as a whole may be in the best position to make the collective decisions about priorities and strategies that will in effect alter the social framework to improve health status due to their relative proximity to the issues by which they are affected (Green & Kreuter, 1991). However, despite this belief, the community may not be the "engine of health promotion", "locus of change", or the "vehicle of emancipation" (Labonté, 1993b, p. 62). Rather it is the small group, often the result of community organization described above, where purpose is created and social change evolves, the subject of further discussion below.

Groups and Groups in Process

The study of groups and group processes is a discipline all in itself, and could not possibly be reviewed here extensively enough to give it justice. Therefore, the purposes

of this portion of this literature review will be to examine what a small group is, and bring attention to some of the many factors affecting groups in process. Specifically, these factors will be related to groups formed, "manufactured" (Raeburn & Rootman, 1998, p. 23), or organized as part of a community development strategy (Labonté, 1993b) to improve health status.

Society is one large group made up of many small, diverse, and overlapping groups that influence the larger society they are a part of (Schultz, 1989). Further, there are many functionally important groups of social control that make up the social aggregate including families, bands, villages, and states (Aristotle as cited in Golembiewski, 1984). Small groups, influential in the social environment, are particularly important and relevant in health promotion, specifically in community development strategies (Labonté, 1993b). Additionally, the role of groups in health promotion has been addressed in the Ottawa Charter (WHO, 1986) in regards to their role in the identification and realization of needs, as well as in the call for intersectoral collaboration to improve health status.

What is a small group? Although some discrepancy exists in the literature about the minimum and maximum numbers of people that constitute a small group, it is generally agreed that a small group consists of at least two people, and no more than what limits meaningful interaction vis-à-vis communication between each member in the group (verbally and non-verbally), in attempts to mutually influence each person in the group (Schultz, 1989; Shaw, 1981; Tubbs, 1984).

Small groups are further characterized by common purposes or goals, norms, cohesiveness, leader behavior, member behavior, decision making process, and curative

or therapeutic factors (Northouse & Northouse, 1992). Goals provide the very reason, rationale, and motivation for the formation of a group. If goals are to be realized it is important that they be clear, realistic, and shared or developed by the group members. Group members regulate each other's behavior and maintain consistent conduct through established rules of behavior, or norms. Norms can be obvious or surreptitious and have the potential to either advance or limit the group's activity. Cohesiveness, described as the "cement that holds the group together" (p. 191), exists in relative amounts in various groups, and urges group members to remain in the group. The group leader's behaviors are vital to the developing group norms, and directing the group toward its goals. The leader is a major source of influence in a group setting and can act positively as a facilitator, or negatively as a barrier depending upon his or her own behaviors. Member behaviors, specifically their roles and communication patterns, also have an important position in group functioning and outcomes. Finally, there are interpersonal processes that affect individual members and the group as a whole that ultimately affect change. These processes include, but are not limited to, instillation of hope, altruism, imitative behavior, and catharsis.

Groups, like the individuals that form them, go through phases of development that define their growth pattern. Thorough reviews have been conducted of group development processes (Ephross & Vassil, 1988; Tubbs, 1984), and have found that group development is temporal in nature, and that the various transition theories of group life are very similar in pattern. There are typically four or five stages of group development. Using Tuckman's (1965) (as cited by Tubbs, 1984) phase definitions which include forming, storming, norming, and performing this process can be described.

After initial formation of the group it progresses through the storming phase characterized by conflict of some kind within the group. The group then proceeds through the norming phase, or the resolution of conflict and development of codes of member conduct and cohesiveness. Last, the group progresses to the performing stage, the phase of maximum productivity and development of consensus within the group. This four-stage model is extended with the addition of the termination or separation phase when the group dissolves (Ephorss & Vassil, 1988).

The small group organized to address health issues in the community is linked through empowerment and community development based values and principles discussed above. Specifically, a small group is empowered and has a high degree of citizen participation if the members are engaged in a democratic process that results when decision-making power is equitably distributed among members, membership is inclusive and committed to democracy, there are healthy relationships among its members, and deliberation occurs democratically (Gastil, 1993). Democratic deliberation is demonstrated by group members when each has an equal and adequate opportunity to speak, does not withhold information or verbally manipulate one another, and has the ability and willingness to listen to each other (Gastil, 1993). Moreover, a group in process is empowered when it is autonomous, effective, in charge of its own affairs, and able to set its own agenda (Raeburn & Rootman, 1998).

The acknowledgement of the small group as the primary means through which the processes of health promotion, empowerment, and community development takes place provides justification to explore and describe these processes in this context. Further, the factors and processes that affect how a group functions forms a vital portion of the

context a group operates within, and are particularly relevant in evaluating the process of creating a healthy community. Specifically, the implementation of this process should be examined in relation to the underlying values and principles of organizational empowerment and community development described above.

Healthy Cities/Communities and Coalitions

The Healthy Cities movement, commonly referred to as the Healthy Communities movement[1], was conceived concurrently by the World Health Organization's (WHO) European office in 1986 (Kickbush, 1989) and in North America by Hancock and Duhl (1986) as a method of putting into action the global concepts of health promotion (Hancock, 1993a). Specifically, the Healthy Communities movement is a method of applying the principles and processes of health promotion outlined in the Ottawa Charter (WHO, 1986), and attempting to meet the targets contained within the WHO's (1981) document Global Strategy for Health for All by the Year 2000 (Baum, 1993; Flynn, 1992; Hancock, 1995). In addition, the concept pays specific attention to both the processes and outcomes that reflect a more equitable distribution of resources and power that results in improved health status (Baum, 1993) through a multisectoral approach, citizen participation and involvement, empowerment, and community development (Hancock, 1995). Essentially, "the goal of Healthy Communities is to promote the well-being and health of communities by collaborative action at the local level" (Chalmers & Bramadat, 1996, p. 721).

A healthy community continually creates and improves the physical and social environments and expands those community resources that enable people to mutually support each other in performing all the functions of life and the development of their

maximum potential (Hancock et al., 1986). Further, a healthy community reflects a process, similar to health promotion and empowerment, by being conscious of health, always endeavoring to improve health status, and considering the effects of all decisions on health (Hancock, 1993a). Components that constitute a healthy city/community include, but are not limited to, a clean, safe, high quality environment; a strong, mutually supportive and non-exploitative community; a diverse, vital, and innovative economy; and relatively high health status (Hancock et al., 1986).

Healthy communities are further distinguished by the role of local government (Baum, 1993; Flynn, 1992; Hancock, 1993a), and individualized approaches to taking relevant and applicable action toward their local concerns and needs (Hayes & Willms, 1990). The involvement and commitment of local governments adds political and legislative support and legitimacy to healthy community projects, specifically as they can influence the social, physical, and economic environmental factors that determine health (Hancock, 1993a, 1995; Hayes & Willms, 1990). Moreover, the involvement of local governments satisfies the criteria set forth in the Ottawa Charter (WHO, 1986) as it relates to interdisciplinary/multisectoral collaboration (Hancock, 1993a). Local government represents one of the many stakeholders in a community and plays an important role in the formation and operation of community services. However, the involvement of government limits the possibility for effective social action by operating within bureaucratic conditions that "stress consensual, incremental change" (Baum, 1993, p. 32). Similar issues have been identified in the empowerment and community development related literature above.

Local government may include civic or municipal bodies or a local branch of a

larger government body. Regional health authorities in the province of Alberta are an example of a local branch of a provincial government body that is charged with managing the care and promoting the health of the constituents that live within its jurisdictional boundaries. Recent political reform and restructuring at the provincial level in Alberta has resulted in significant changes that impacted the entire provincial health system. From a historical perspective, the integration of separate public health units in 1994 into the regional structure was followed by boundary changes and the formation of 17 new regional health authorities. Government legislation requires regional health authorities to plan for and deliver health promotion, however the regional health authorities are left with some autonomy regarding the planning, developing, and implementing these activities.

Unique spatial, temporal, and social conditions and relations vary in each community and must be considered in context (Hayes & Willms, 1990). A model of how a healthy community should be created has never been imposed in the Healthy Communities movement, thus communities have the flexibility to identify and assess health needs that are relevant and important to them, as well as plan, implement, and in many cases evaluate their own strategies to address the identified needs. Further, this allows communities to take into account the space, time, and environmental conditions singular to each community in general, and provide the opportunity for capacity building within a community itself.

The process of creating a healthy community vis-á-vis the small group is associated with health promotion through certain values and beliefs (British Columbia Ministry of Health, 1989) that also happen to reflect the principles of empowerment,

community development, and democratic group processes described above. First, health is removed from the disease continuum and aligns itself more closely to the WHO (1946, 1986) definitions that consider health as a state of physical, mental, and social well-being, and a resource for everyday living that emphasizes social, physical, and personal capacities. Second, it is accepted that communities have both strengths and problems, but communities are also believed to have the ability to solve these problems by drawing on their strengths and by realizing their potential. Third, the process should encourage individuals to identify their own needs, set priorities, and take responsibility for their own well-being, while fostering a supportive, nurturing environment. Last, the process is believed to accommodate the context in which it takes place, and is based on participation by all those affected, directly and indirectly, at each stage of the process.

Historically, the group that has been formed for the purposes of creating a healthy community is typically multisectoral (Hancock, 1995). Outside of the representation of local government, other groups that comprise a healthy community project include businesses, non-governmental agencies, and citizen groups to develop a broad range of strategies that address health related issues (Hancock, 1993a; Hancock, 1995). These coalitions, or "groups of groups" (Labonté, 1993b, p. 76), were found in a review of related literature to be a collection of individuals representing diverse organizations or interest groups that work together to achieve a common goal, and combine their human and material resources to effect a specific change the members are unable to bring about independently (Butterfoss, Goodman, & Wandersman, 1993).

There is an important distinction between institution-created and community group coalitions, as each will have a varying process used to achieve similar goals

(Labonté, 1993b). An institution-created coalition reflects a process where health professionals define the issues and develop the strategies to solve problems, but involve community members and groups to assist in the process. On the other hand, community group coalitions are concerned with risk conditions in the social environment that affect both the individual and community at large. These issues reiterate those that discriminate between community-based programming and community development discussed here previously.

Factors that affect the formation, implementation, and maintenance of coalitions are similar to that arising out of small group theory, and include degree of formality, characteristics of leadership and membership, organizational climate, and relationships with external supports (Butterfoss, et al., 1993). These factors are particularly relevant in determining if and how coalition goals and the resultant outcomes are arrived at (Butterfoss, et al., 1993), and more specifically with respect to the process of creating a healthy community. Moreover, each partner in such a group will have distinguishing features that will directly and indirectly affect the group's development (Scott & Thurston, 1997).

Summary and Conclusion

In an attempt to provide sound rationale for conducting research to explore, describe, and evaluate the process of creating a healthy community, several concepts have been reviewed. The concepts that were considered meaningful to the process of creating a healthy community included health promotion, empowerment, community development, the small group, and, of course, the Healthy Communities movement itself. These concepts relate to each other through common fundamental values and principles

inherent in each. These commonalties include, but are not limited to, an equal opportunity for participation and multisectoral and community representation and collaboration for the purposes of building individual and community capacity with the expectation of influencing the factors that affect health status.

Health promotion was determined, as identified through a review of various definitions of the term, to represent a process that provides the opportunity for individuals and communities to gain control of the factors that influence their health. Specifically, the notion of health promotion was regarded as any activity directed toward improving people's health and well-being and typically took on the form of illness prevention, health education, and healthy public policy. Moreover, health promotion has been cited as a process that identifies and acts on risk conditions in the social and physical environment, and not just those resulting from individual behavior, which potentially limits the achievement of relatively higher levels of health status.

The concept of empowerment was reviewed and found to be the rudimentary constituent of health promotion practice. Empowerment, like health promotion, is also considered to be a process as well as the result or outcome of the process. This process is based upon the discrepancy in the relative amounts of power in society that has resulted from the very social structures and environment developed and built by those that exist within it. A relatively low level of power is a risk factor for disease, and the empowerment process will provide, and result in, both a perceived increase in power, and an actual reallocation of resources so that individuals, organizations, and communities may influence the factors that affect their health.

Community development is a health promotion strategy that provides the means for the health promoter to implement the empowerment process, and specifically to assist in the development and application of skills and knowledge so that communities are better apt to influence the factors that affect their health. The level of participation of the community is particularly relevant in such strategies, as it is quite possible for the health professional or governing body to control the processes rather than allow the community to become engaged and develop the necessary skills and knowledge required to affect change.

The small group, being influential in society, is the primary vehicle for community development initiatives. The small group provides the opportunity for meaningful interaction and sharing of individual experiences that influence each member. All groups, not just the ones formed with the intent of addressing health issues in the community, are similar in that they have a goal or purpose, go through stages of development, and are influenced by characteristics of the group and the environment. The empowerment process is functioning in the small group when members share information, in the decision-making process, and in the control of the group's activities. The small group is considered empowered when it has the ability to influence the social and physical environment in which it exists.

The Healthy Communities movement is a health promotion strategy that embodies the processes of empowerment and community development in the context of a small group, often organized as a community health coalition. Such coalitions are typically multisectoral in nature and characterized by the active role of local government that sanctions and legitimizes the process. Healthy Community projects are further

characterized by the fundamental belief that despite the health related issues that exist within a community, the community has the resources and abilities to develop and implement solutions to those problems, and that all members of the community are allowed to actively take part in this process.

Therefore, one may conclude that processes are the dominant features of the practice of promoting health. These processes include, but are not limited to, empowerment, community development, and small group development. Specifically, these processes are utilized or function to better able individuals and communities take control of, and influence the factors that affect their health.. Further, these processes can not be disentangled or extricated from each other due to being commonly bound by the principles of citizen participation and community control. The Healthy Communities movement is a manifestation of the processes of empowerment and community development with the goal of the improving the health status of individuals and communities.

Research Questions. The identification of the Healthy Communities movement as being representative of the process of health promotion as it has been outlined in the Ottawa Charter for Health Promotion (WHO, 1986) provides solid grounds for knowledge development and research. In particular, research that explores, describes, and evaluates the process of creating a healthy community in reference to the principles of empowerment and community development, and in the context the community health coalition, is particularly relevant.

Therefore, this research study will attempt to answer the following questions:

1. What is the process of creating a healthy community in a rural setting?,

2. What is the role of both local government and the Regional Health Authority in the process of creating a healthy community in this context?, and
3. Has the process of creating a healthy community in this context been implemented as intended, particularly with respect to the fundamental values and principles of health promotion, empowerment, and community development?

The potential implications of this evaluation are significant. The results of this research project will describe the process of creating a healthy community, determine the effects of the local government and Regional Health Authority on the process, and determine if the healthy community project was implemented as intended, particularly with respect to the values and principles associated with such a project in this context. This research will provide vital information to all stakeholders and decision-makers regarding the strengths and limitations of the process as it has been applied in the context of the community health coalition. In addition, this information may be used by the coalition to build upon the strengths and improve the process in this specific context. Further, the information generated by this research will also allow the opportunity for the stakeholders to reflect on how certain outcomes have been achieved with respect to how the process functions. Knowledge of the strengths and limitations of the process may also be carried into other communities in the Regional Health Authority's jurisdiction, the province of Alberta, and Canada as a whole, that may implement a Healthy Community project of their own. Last, the knowledge and information generated by this research may assist in the development of health promotion, empowerment, community development, and group process theory.

Chapter 3

Methods and Procedures

The Research Design

Process evaluation research is often considered as one part of a comprehensive program evaluation to determine how a program achieves what it does (Dehar, Casswell, & Duignan, 1993). There are many thoughts on what a process evaluation should address (see Dehar et al., 1993), however it is generally agreed that it should focus on at least one of the following: 1) the extent to which a program reaches its target population; 2) the frequency programs are delivered or participated in (also referred to as 'dose'); 3) the fidelity of program implementation as it was originally intended; 4) the monitoring of the context or variability of the environment in which the program is implemented; and 5) to assist in the interpretation of intended and unintended program impacts and outcomes (Dehar et al., 1993; Flora, et al., 1993; Fink, 1993; McGraw, et al., 1989; Patton, 1990; Rossi & Freeman, 1993).

Process evaluation research is important in the community development/empowerment context as individuals or groups implementing such projects often have control over the methods used to reach a certain outcome, unlike the outcomes themselves for which there is intention but no guarantee of attaining (Patton, 1997). Additionally, process evaluations may facilitate reaching outcomes by identifying advantages and limitations of certain aspects of specific processes used to reach those outcomes (Poland, 1996a). Process evaluations of such health promotion programs are particularly amendable to qualitative or naturalistic research methods (McKinlay, 1996; Patton, 1997; Posavac & Carey, 1992). Specifically, such evaluation research attempts to

determine participants' experiences in, and perceptions of a program, what the strengths and weaknesses of the program's process are, and what can be done to improve both formal and informal processes used to increase the health status of a community (Patton, 1997).

The Healthy Communities movement is decidedly at a point where discriminate examination would contribute to the knowledge of how such projects are implemented, and the outcomes arrived at (Poland, 1996a). Further, since the movement embodies values of the "new public health" (p. 238), which includes attempting to influence the broad determinants of health at the community level through intersectoral coalition building, public participation, and community development, it is important to develop an understanding of the challenges associated with such an approach. Potential foci for such process evaluation research of Healthy Communities projects include concepts, principles, or strategies guiding the process, stages of development of the project, and barriers and facilitators of project development (Poland, 1996a). Specifically, those elements that exemplify the Healthy Communities movement, such as multisectoral coalitions, community development, public participation, and equity, to name a few (Poland, 1996b) are particularly amendable to evaluation research.

Appropriately, such an evaluation may examine how these strategies are performed, and review the agreement between the intended and actual process implemented to create a healthy community. Moreover, information about the activities and conditions that act as obstacles, or support and facilitate the process of creating a healthy community, might prove to be valuable information both formatively, and in relation to conceptual and theoretical principles of health promotion, empowerment, and

community development in the healthy community context (Poland, 1996b). Ethnographic studies that allow individuals and communities to tell their own stories in relation to the above, have been identified as a viable research design for such research (Hancock, 1993b).

Qualitative research methodology is process orientated inquiry used to understand, interpret and describe phenomena, settings, or events from a subjective and emic perspective (Morse & Field, 1995). Ethnography, a qualitative research design, is rooted in cultural anthropology where it was used to gather details on the patterns and processes of everyday life within and across various cultures from the perspective of the participants (Hammersley & Atkinson, 1995; Morse & Field, 1995). Ethnographic research often focuses on specific values, beliefs, events, and practices of certain groups, and results in an end product that informs the reader of specific patterns of behaviors and processes from the perspective of the group members themselves. More specifically, the use of an ethnographic design typically employs data collection techniques such as face-to-face, in-depth interviews and participant observation for the purposes of exploring and describing aspects of social patterns and observed conduct.

Exploration on the part of the researcher affords opportunities to study little understood phenomenon, or identify or discover important variables, and learn about its natural features (Marshall & Rossman, 1995). Description, on the other hand, is concerned with documenting, in the form of a detailed account, the phenomenon of interest to the researcher and the reader (Marshall & Rossman, 1995). The use of the ethnographic design for the purposes of exploration and description is particularly fitting as these research activities are then based upon the experiences of the participant

involved in the phenomenon of interest, where descriptive data is typically treated as fact (Wolcott, 1994).

Therefore, the methods of this research study were qualitative in nature, utilizing the design principles and practices of ethnography to determine, describe, and evaluate the process of creating a healthy community in a rural setting in Alberta. Specifically, one-on-one interviews and participant observation techniques were applied to gather data for this study.

Sample

The subject of this study is a community health coalition in rural Alberta currently in the process of creating a healthy community. The coalition was formally established in October of 1996 when the municipal government of a small rural community established a formal partnership with the local Regional Health Authority to support the health authority's efforts in creating healthier communities. The two founding partners introduced the healthy community concept to the community through a town hall style meeting in January of 1997. The coalition held its first official meeting in February of 1997. This is a pilot project and the first and only healthy community project currently underway in this health region. This particular community health coalition was chosen for this study due to its geographic location that is conveniently located near to the investigator's residence.

The coalition currently boasts 50 members, however the membership numbers continue to grow on a monthly basis. Coalition membership is open to any individual community member. An individual is considered a member when he or she is on the coalition's mailing list, which entitles the individual to receive coalition meeting minutes

through the mail. The demographic characteristics of the community health coalition membership vary considerably in gender, age, and occupational status. Specifically, there are 38 female and 12 male members, 2 of which are currently under 18 years of age. The coalition membership includes two individuals who represent the local Regional Health Authority and the town's council in an official capacity, however the remainder of the membership is made of community members that do not represent any specific agency, institution, or organization. The occupations of coalition members range from homemakers to nurses and dentists, to those that are retired. It has been assumed by this investigator that most of the individuals have joined the coalition as community members taking the opportunity to be more active and become involved in the efforts to improve the health of their community.

Sample Selection

The selection of a sample for this study was both purposive and convenient (Miles & Huberman, 1994). First, coalition members were considered as potential informants if they were 'active' within the coalition itself. Specifically, members were considered active if they had attended a minimum of two coalition meetings in the twelve months prior to the initiation of the data collection process for this research. Coalition meetings are currently held the second and fourth Tuesday of every month in the evening for approximately two hours, with the exception of July, August, and December when activity is temporarily suspended for the summer months and Christmas respectively. Based upon information provided to the investigator by the co-chair of the community health coalition, the number of active members was estimated to be no more than 20. Selecting potential informants with varying levels of participation in meeting activity was

believed to provide the opportunity to describe a diverse number of experiences and common patterns relating to the healthy community process that may have cut across the variations in coalition meeting attendance. Furthermore, participants in the interview process had to be adult members of the community health coalition. An adult member was considered to be at least 18 years of age. In addition, the method used to recruit subjects (described below) was dependent upon potential informants volunteering to participate in the data collection process, thus making these subjects easily accessible to the investigator.

Recruitment of potential interview respondents from the sample was initiated by including a letter in the coalition's meeting minutes from the coalition co-chairs informing the membership of the study. A reply form and a stamped envelope addressed to the investigator was also included with the letter requesting all members who were not interested in taking part in the study return the completed form to the investigator. A generic copy of the letter and reply form are included in Appendix A. The letter informed the members about the study, the eligibility criteria for participation in the interviews, and the investigator's contact telephone number if anyone had any questions about the study. Minutes of the past coalition meeting, and agendas for the next meeting were sent out to the membership about one week prior to the next meeting. Potential respondents were asked to return the reply form to the investigator using the postage paid envelope within a two-week period after the minutes were mailed if the potential respondent was not interested in participating in an interview. Once a list of participants had been finalized data collection commenced as described below.

Using documented minutes of coalition meetings, and the sample selection criteria described above to ensure potential respondents fell within the inclusion parameters, 21 coalition members were identified as being eligible to participate in an interview. Two of the 21 eligible members returned the reply form to the investigator indicating they were not interested in participating in the study, and one member chose not to participate only after the investigator made telephone contact with the member. The investigator contacted the eligible members who did not return the completed reply form, via telephone, to schedule a convenient date and time to meet and discuss the study, and if possible, conduct the interview. A copy of the information sheet (Appendix B) and consent form (Appendix C), with a verbal overview of both, was given to the potential respondent at the time of data collection. Appointments were scheduled so that those members who attended the least number of coalition meetings in the 12 months prior to the study beginning were interviewed first, and interviews continued, coinciding with the observation period, with members who had attended an increasingly greater number of coalition meetings until data collection was complete.

Informed consent was received and interviews were conducted with 18 eligible coalition members. Respondents had who attended as few as two and up too as many as 19 meetings in the 12 months prior to the initiation of this study.

Methods and Instruments

Data were collected through two primary means: a semi-structured interview of individual coalition members, and participant observation of coalition meetings, both of which were conducted by the researcher-investigator.

Interviews. The advantages of interviews include the opportunity to directly observe the participant when giving responses, and to clarify questions and responses if misunderstood by either the participant or the interviewer (Brink & Wood, 1994). In addition, the interview may possibly lead to new information and viewpoints that may not have been considered prior to data collection (Posovac & Carey, 1992). However, interviews also tend to utilize a great number of resources, specifically time and money. First, time is considered a valuable commodity to both the researcher and the potential respondent. These costs are often weighed in terms of lost opportunity (University of Manitoba Research Ltd., 1987). Second, the cost of interviews in terms of dollars can also be significant. Outside of the cost in dollars of the interviewer's and respondent's time, the cost of transcribing and analyzing the large amount of data that results from interviews can also be an expensive endeavor. Moreover, interviews may be limited as they can only elicit perceptions and perspectives that are subject to distortion due to bias, politics, and level of awareness (Patton, 1990). However, this may be desirable from the investigator's point of view as it provides the opportunity to explore the internal states of the participants (Patton, 1990), and recognize and accept the possibility of multiple realities (Fetterman, 1989).

The interview portion of the data collection process was guided by one question that attempted to elicit a response that provided the necessary information from the participants regarding the process of creating a healthy community in this context. The grand tour (Spradley, 1979) question for this research investigation was 'I am very interested to learn about the community health coalition, can you tell me about your experiences as a member of it?' Probing questions were utilized only when it was felt

that more complete and detailed information was available or desired from the participant. It was the intention of this investigator to allow the participant to provide as much information regarding the coalition's process with as little encumbrance as possible. The interview guide and potential probes are included in Appendix D.

This investigator developed the grand tour question in the interview guide for this study based upon the purpose of this research, and the focus on process. A panel of peers was convened to determine the appropriateness and effectiveness of the grand tour question and the potential probes for eliciting the desired information. Further, the interview guide was pilot tested using a sample of two members of the community health coalition who were known to fit the selection criteria. The results of the pilot provided the opportunity to evaluate the effectiveness of the interview guide in eliciting the desired responses. Further adjustments were made to the interview guide based upon the responses made by the pilot sample.

For the most part interviews were conducted in an office in the community provided by the Regional Health Authority. This location is central in the community, easily identifiable, and convenient, and as such deemed suitable for interviewing purposes. If this location was unsatisfactory to the participant, for confidentiality or other reasons, a location was chosen by the participant and mutually agreed upon by the investigator. Alternate locations for interviews included a meeting room in the community's recreation complex, a participant's home or office, and a local restaurant. Interviews ranged between 30 and 90 minutes long, and although it was believed that a maximum of two interviews for each participant might have been necessary, one for the

initial data collection, and the second, if required, for clarification purposes only, no second interviews were conducted for that reason.

Raw data were collected by tape recording the interview and taking field notes. The tape-recorded interviews were immediately transcribed into a word processing file, and imported into NUD-IST version 4.0 for the purposes of analysis. Field notes were kept in a field journal that provided a medium for recording of setting, any non-verbal information a participant exhibited, major themes, key phrases, and lists of major points expressed by the participant (Patton, 1990).

Participant Observation. Observation of the coalition meetings provided the opportunity to gather first hand data on how the coalition operated, and provided rich and potentially important information that could not be anticipated (Fink, 1993; Posavac & Carey, 1992). The limitations of observation included the possibility that the observer affected the situation in unknown ways, those being observed behaved atypically due to surveillance, and selective perception of the observer may have distorted the data (Fink, 1993; Patton, 1990).

The observation period was continuous to reduce any feelings of artificiality or formality over a time period of 17 weeks, and were uninterrupted in the sense that all coalition meetings held during the 17 weeks were observed, with the exception of one, at week 15. In addition to the coalition meetings, meetings of two sub-committees of the coalition were also observed to ensure that a thorough representation of the process of creating a healthy community in this context would be possible. In total, seven coalition and three sub-committee meetings were observed over the 17 week time period. The location, the number of coalition members who attended the meetings, and the content of

the meetings varied throughout the observation period. In total, approximately 17.5 hours was spent observing the coalition and coalition sub-committee meetings.

Observation was overt to limit possible subversive feelings of coalition members. However, to limit the possible disruption of taking field notes during observation, entries were limited to setting, emergent ideas, and key words and events. It was believed that this limited any perceptions of threat and inappropriateness that may have been arrived at by coalition members during the observation of meetings (Hammersley & Atkinson, 1983; Smith, 1996). Field notes generated during the observation of coalition meetings were kept in a field journal and then transcribed into a computer word processor document. The observation of coalition meetings also provided insight into the forming of questions during the interviews of coalition members. More specifically, key events or decision making points observed during meetings provided an opportunity for the investigator to question a respondent during an interview about the event in order to develop an understanding of its significance and place within the process of creating a healthy community in this context.

It was agreed between the coalition and the researcher at the beginning of the project that the observer would take on a role of moderate participation – that is to say, that if the coalition felt it must draw on the experiences of the observer/investigator it may have, but a conscious effort to maintain a balance between insider and outsider was made by both the observer and the coalition (Spradley, 1980).

Data Analysis

Data analysis of a transcribed interview commenced once the written copy of the tapes had been sent to the respective interview respondent with the provision for both the

investigator and interview participant to clarify any inconsistencies or follow-up with a second interview.

Based upon the strategy described by Patton (1990) for analyzing interviews, the case analysis approach was initially utilized. Using this approach provided the opportunity to describe the answers and perspectives of the different participants to questions in the interview guide. Further, such an approach generated insight into effective practices and processes across the experiences of each participant.

All transcribed and verified data were imported into NUD-IST version 4.0 to facilitate the process of indexing, searching, and coding during analysis. The first step in the analysis of the interviews was a careful reading of the transcripts while listening to the interview tapes to become familiar with the contents. During this process the data were 'cleaned' by correcting all spelling mistakes and other inconsistencies between the taped interview and the written copy prior to coding. This was followed by the identification of any patterns of interest, inconsistencies or contradictions among the views, expressed beliefs, or attitudes of participants and what they do, and determination of how the data relates between subjects (Hammersley & Atkinson, 1995). This process of question analysis produced a stable set of categories that were used to systematically code all data in terms of these categories (Morse & Field, 1995). The codes developed in the content analysis were based upon the participants' own words and indigenous concepts as much as possible (Morse & Field, 1995; Patton, 1990). After the initial coding process, subjecting the data to second level coding to re-categorize and condense codes summarized the relationships between data sets, and identified and linked concepts present in the data (Morse & Field, 1995).

Observational data were analyzed and organized to describe the important processes that occur within the context of the coalition meetings. Codes emerged from the observational data based upon where the observation fit into the coalition's process, or the principles and values that guide the process. The coded observational data were then consolidated and compared to the interview data to develop a broad understanding of the process of creating a healthy community in this context.

Rigor

The credibility of this investigation was maintained by ensuring comprehensive data collection, gathering diverse perspectives, and verifying collected data with the stakeholders (Horne, 1995). The collection of comprehensive data through both interviews and observation reflected the reality of what and how the process functions from perspective of the coalition members in the context of the community health coalition itself. The use of both interview and participant observation data gathering processes provided the opportunity to test one source of data against the other, challenge alternative explanations that emerged from either data source, and understand more completely the events of coalition meetings and statements made by informants (Fetterman, 1989). By gathering data from members with various activity levels, a diverse opinion on what the process is and how it functions could be compared.

Verification of the data collected from interviews and observations by the stakeholders ensured these statements and events were accurate. Coalition members were invited to a single verification session after data analysis was complete and the findings had been synthesized. This process provided an opportunity for the coalition members to share in the conclusions and interpretations made by the investigator, and bring forward

any alternative explanations for the patterns observed (Posavac & Carey, 1992). The verification process also provided the opportunity for the coalition to openly draw and reflect upon on the conclusions made by the investigator, and speak openly about process issues identified. When the coalition did identify potential gaps in the findings the investigator was able to revisit the data to refine the results if the gathered data supported the suggested modification. In addition, the verification process provided the investigator with a measure of validation when the participants remarked that the process of creating a healthy community in this context was accurately portrayed by this study.

Due to the qualitative nature of this research, the dependability of the investigation was assured through the recognition of the investigator's own subjectivity and ensuring the integrity of the data gathering processes and analysis procedures (Horne, 1995). By recognizing the investigator's own ideas and feelings regarding how the process of creating a healthy community in this context, the influence of this perspective when observing and analyzing data was taken into account. Ensuring the integrity of the collection and analysis of data through careful documentation of the procedures, the rationale behind code development, the recognition of themes, and the conclusions made, provides an audit trail for others to determine why differences in findings or opinions may result.

Ethical Considerations

In order to gain access to the community health coalition and its members for the purposes of this research, the investigator-researcher met with the coalition to introduce and propose this research project, and describe the research methodology and design to

the group. The coalition made the decision to participate in the research project after deliberation by the coalition members that did not include the investigator.

Interview subjects for this investigation volunteered. All potential informants were provided an information sheet (Appendix B) that outlined the details of the research protocols and specifics related to the interview prior to the informed consent being received. Participants were informed that they may terminate the interview, or ask that the tape recorder be turned off, at any time during the interview. The subjects were also informed of the right to refuse to answer any questions, and in addition, ask any questions of the interviewer/investigator at any time.

The potential risks to the coalition as a whole and the individual coalition members was limited to the presence of the principal investigator/observer at coalition meetings and the potential of identification of an interview participant. The mere fact that the process was being investigated may have been enough to alter how the group functions, however there was the possibility that this may be to the coalition's benefit. Also, without the appropriate safeguards there was the potential for the researcher to become involved in the coalition to the point where that involvement altered how the group functioned. However, coalition meetings occur in a public forum, are open to all members of the community, and observation was overt with the real purpose known to all coalition members. Moreover, the information sharing and interaction that occurred during coalition meetings was not private and thus reduced the risk of any possible negative side effects of observation by the researcher.

The anonymity of the subjects was be protected by: 1) transcribing the data by code number; 2) storing the interview tapes, transcribed notes stored on computer disk or

as a hard copy, in locked cabinets, in a locked room; and 3) storing the consent forms and identifying data in a locked cabinet separate from the interview tapes and transcribed notes. Any person or place names or potentially identifying data that appeared in the transcribed interview or field journal notes were removed. The interview tapes were erased once the information contained had been transcribed and verified by the respondents. The final report does not include any identifying information about the participants. Further, due to the relative small size of the community the coalition operates within, and the small number of active coalition members, not only were person and place names removed from all transcripts and not placed into any final reports, but any other information or data that may potentially identify respondents was also removed from all transcripts and not used in any reports.

Chapter 4

Results

Data collected and analyzed from the identified sample resulted in the emergence of a model of the process of creating a healthy community in this context. The results of the interview and participant-observation processes, the categories that emerged during analysis, and the aspects that characterize the process of creating a healthy community in this context are discussed below.

Resulting Categories

Analysis of interview and observation data resulted in the development of categories that may be organized to describe the process of creating a healthy community in this context. Two categories emerged from the coded data and include a) coalition framework, and b) coalition function. The sub-categories, identified during analysis, provide a more refined description of the various characteristics of the categories of the process of creating a healthy community. Sub-categories which constitute the category coalition framework include a) the coalition purpose, and b) membership criteria and characteristics. Sub-categories of the coalition function category include a) need identification, b) decision making, c) action and mobilization, d) evaluation, and e) sustainability. Although these categories and sub-categories have been described as being somewhat mutually exclusive for explanatory purposes, in reality the categories and sub-categories are somewhat intermingled, with each category and sub-category influencing each other in the process of creating a healthy community.

Verbatim quotations made by respondents included in this text were chosen by the investigator to best represent the various characteristics of the coalition itself, the process

of creating a healthy community in this context, and relate to the research questions guiding this study. Quotations used for descriptive purposes have been indexed to identify the respondents code number randomly assigned by the investigator, and the text units (line numbers) allocated by the data analysis software to the transcribed interviews. For example (01, 356 - 360) refers to the interview participant coded as 01 and the allocated text units 356 to 360 inclusive in the transcribed interviews.

Coalition Framework

In order for the efforts of a small group or organization to be effective they require a framework that will define the actions the group implements to influence its environment. In the context of the community health coalition studied in this research, both the purpose of the group, and the criteria and characteristics of the coalition's membership provide this framework. Specifically, the purpose of the coalition provides the conditions for how the group intends to act, while the criteria for membership, as well as its characteristics, provides the collective status as an organization that will execute the steps required to fulfill the purpose.

Coalition Purpose. Individuals, or individuals representing groups, participating in processes characterized by interest are linked by goals or a shared purpose. By providing reason, rationale, and motivation for the group, the purpose must be clear, realistic, and shared or developed by the group members (Northouse & Northouse, 1992). The members of this coalition, in essence, have defined the purpose of the coalition by participating in a Healthy Communities Project, and second, by their actions as a group. In order to develop a sense of what the coalition's purpose, the members that were interviewed were given the opportunity to describe what they felt the purpose or mandate

of the coalition was. Despite the belief in the literature that groups have a shared purpose, and considering the coalition members' shared vision of creating a healthy community, respondents had inconsistent ideas about the purpose of the coalition itself. However, these ideas were not necessarily incompatible. Examples of the challenge in attempting to define a singular purpose of the coalition are reflected in the comments of this respondent:

> "…the purpose for each person, I think, is different, so I don't think the whole goal for everyone is the same…the purpose is if someone is interested in, you know, helping form a healthy community in their own way, like go for it, come join us, lets do it…" (08, 339 - 343)

One distinct purpose of the coalition identified by respondents, and supported by observation, is that the coalition serves as a mechanism or forum for public discourse regarding health related issues of the community:

> "[The purpose is to] bring to other peoples' knowledge things that maybe need to be corrected to improve the overall health of the community." (03, 163 - 165)

> "I think part of it has social purposes, I mean you're bringing people together of like interests to talk in dialogue. You're giving them a sounding board as to where they can field these issues and it's a way of highlighting health issues in the community…just sharing ideas and interests…" (04, 296 - 301)

Moving beyond this relatively simple description of the purpose of the coalition where health related issues affecting the community are simply brought to light, other respondents have described a higher level of interaction between those that are involved in the process:

> "To me, what I feel about the coalition's responsibility is, is to partnership with other organizations and other people in the community, to help make [the town] a better place to live for everybody involved in it. And the coalition's basic mandate should be to partnership with other people, not to run as its own in most cases. It should be more as a partnership." (01, 742 - 748)

> "…the whole idea of the coalition as I understand it to be very much a networking group and the importance of having links and partnerships with other associations in the community and the region really impressed me because I think that's what lacking so much, but there are a lot of people doing a lot of good things but if only they could get together and be part of a larger body more would happen." (06, 47 - 53)

> "The purpose of the coalition as I see it is to actively, pro-actively create a forum for ah people to come together individually or representing different groups to promote the health and wellness of their community in a form that is capable of handling diverse views, like the diversity around the table, and to develop some

consensus about what is good for the community and carry that forward in various ways…in various strategies, various projects if you like." (17, 68 - 72).

The idea about networking and forming partnerships for the purposes of sharing information, skills, and knowledge in order to develop local solutions to community issues seems to exemplify the purpose of this coalition. In fact, the coalition's own terms of reference describe the role of the coalition as facilitating networking and collaboration, and promoting cooperation within the community. Further, a look back at the coalition's history explains that the coalition was formed initially by a partnership agreement between the Regional Health Authority the community resides within, and the local municipality.

Although networking and forming partnerships in order to work together for the common good of the community may be the underlying purpose of this coalition; there are two marked differences in what respondents say a partnership entails. First, a partnership may simply be between two groups, or a group of individuals, brought together through the coalition and working to resolve the issues that affect the health of the community. In this sense, a partnership has been described as:

"People working together for the common good of the community." (14, 249)

"What I think of in that is working together, finding people who have a common interest, but again being equals ahm and ah that that has to do with looking at the

needs, defining the needs, developing plans for those needs ahm and then working forward to implement whatever plans are put into place." (04 525 - 529)

"…people working together, people with different resources and different capabilities working together to achieve a common goal." (07, 279 - 280)

These notions of partnership are supported by observational data. For example, during the observation period a group of individuals with concerns about accessible transportation in the community were introduced to each other at a coalition meeting. Since that time the group has taken specific steps to engage others in the community to participate in finding a solution to transportation needs, as well as gather information from those affected by the availability of accessible transportation in the community. Specifically, current local transportation providers, seniors, local service clubs, and the local municipality have been working together to determine the requirements for accessible transportation in the community. Another example observed was the formation of a partnership between the Regional Health Authority, child and social services, and the coalition to promote the affects of alcohol on a fetus (fetal alcohol syndrome or FAS) within the community.

A second type of partnership is demonstrated when the coalition is acting as group of individuals with an assortment of specialized skills and knowledge. In this instance the coalition shares these skills and knowledge with other individuals or groups in the community who wish to influence their environment to improve health by guiding them through the process. As one respondent put it:

> "…the coalition gives the community some guidance, some leadership, and perhaps some direction in terms of addressing some of the things they need to do." (09 16 - 19).

More specifically:

> "…the coalition is sort of realizing that…we have to step back a bit and just offer some assistance, facilitation, stuff like that…" (16, 88 - 90)

The coalition provides "facilitation" and "assistance" by:

> "…assisting people, assisting a group in understanding what it is they have, what it is they want, fleshing that out…and perhaps how they can get to where they want to go." (10, 292 - 296)

The idea of the coalition as a resource in the community facilitating and providing assistance, guidance, and leadership may be the result of the belief by the membership of the relative amount of local "expertise" within the coalition as suggested by this respondent:

> "The coalition, by looking at expertise around the table can say 'look', and we do have a number of facilitators around the table, 'is sure we'll go in there and help you facilitate and help you organize, but you have to find the people to meet, and

> you have to come up with the ideas, and you have to bring it back to the table. We'll give you ideas on how you have a meeting, if you need someone to come in and listen to a party; we have people on the committee that will do that.' I think it's a resource more than actually doing the work." (12, 174 - 182)

A specific example of the coalition facilitating, or acting as a resource for others in the community cited by many of the respondents who were interviewed was a project that organized the junior and senior high school aged youth in the community in response to a municipally sponsored proposed curfew by-law. The coalition took specific action to organize the youth so that they could speak for themselves to the municipal council regarding the proposed by-law, as well as issues about safety in the community. The coalition members trained some students to act as facilitators in order to gather opinions from the student body regarding the curfew, as well as alternatives about how to solve some of the problems in the community that had resulted in the proposition of the curfew. The coalition also assisted the students to synthesize the information gathered, write a report, and present the report to the municipal council. This particular action may represent empowerment at the community level (Israel et al., 1994), and the intergroup level (Shah, 1990 as cited in Labonté, 1993a) described above. Specifically, participation in activities and advocacy in pursuit of a common goal in order to influence the larger system (community and political in this case) has been demonstrated.

The coalition is not limited to networking and partnering for the purposes of identifying and solving health-related issues in the community. Another reason for networking is simply a social one. Respondents identified that the coalition also has a

social purpose, one that allows them to meet others that live in the community and have "fun".

> "…I've met great people through out um, all different aspects of the community old, young that sort of thing. Um, so in that way just personally establishing myself in [town] has been a big help just to make me feel connected that type of thing." (08, 8 - 12)

> "…the people that attend the meetings often also have become good friends, I mean it it's also a social thing, and since part of our purpose was to make sure we were having fun while we doing all of this stuff…" (15, 217 - 219)

> " It's been fun and I like committees that are fun, ahm its been interesting I think I've made some friends on the committee that I know I will cherish for a long time in the future because I plan to stay in this community for a long time…" (17, 11 - 13)

Yet another description of the purpose of the coalition as described by one respondent suggests that the coalition is "an advocate for healthy public policy" (04, 312). Although most respondents did not share this view, observational data suggest that the inclination toward supporting healthy public policy is sporadic. For example, as described above, the coalition had been working on increasing awareness of fetal alcohol syndrome in the community. The group was aware of other communities in Canada that

had implemented policies that require signs in the restrooms of establishments that serve alcoholic beverages warning of the effects of alcohol on a fetus. Despite this knowledge, the coalition had not worked toward advocating for a similar policy in this community. Alternatively, the coalition had supported and worked towards amending land use by-laws for the provision of a community garden, worked against the implementation of the aforementioned youth curfew by-law, and supported an integrated herbicide/pesticide use policy in the community.

Although there are several different ideas about what the purpose of the coalition is, these differences in opinion and action seem to be tolerated and even welcomed, as one respondent put it:

> "…everybody that seems to be a member of the coalition does have a perspective that they are looking at it from and thinks they're hoping to achieve, to enhance the life of the community. And they have their own agendas and that's fine, we can have all our own agendas and work together towards a common need." (07, 61 - 66).

The idea that a group of individuals can come together and work towards a common need or goal, but with different or more "urgent interests" (p. 156) in a positive manner, within such a framework, has been identified in an evaluation of Healthy Communities projects elsewhere (Ouellet, Durand & Forget, 1994). Additionally, individual goals that are based upon specific needs and desires of group members, and group goals that are shared

among the membership have been found to operate simultaneously in small groups (Northouse & Northouse, 1992).

However, the ambiguity of the purpose of the coalition had also been identified as an issue, as these respondents commented:

> "I don't know its everybody's thing, but you know there's so much that overlaps in every area it's hard to know where to start and where to stop with this coalition. It's supposed to encompass the whole community ok, that takes in everything…"(13, 213 - 216).

> "Well I think that we're not concrete enough, ok that's just one personal thought in that we're not concrete, we don't have a laid out program…a lot of people are, you know, just need a little more direction, and if we did have I'm sure you know if we had specific programs where we needed some of these people on the list to help they would. (16, 370 - 374).

> "…our role as a coalition was when set forth in the beginning, and we were hoping when we started that we would have enough representation from all the different facets that if someone did come forward you would have the relevant person there, but that hasn't worked out which was probably ah it would be pretty unrealistic to think that twice a month you can get together that many people for sort of a nebulous reason because there's no real reason for everybody to be there but that doesn't mean that we don't have access to them…" (11, 103 - 107)

Despite the potential challenges associated with the many different views of the purpose of the coalition, its purpose is essentially driven by the vision of creating a healthy community. Such multi-purpose coalitions can accommodate several goals, as well as exchange resources and direct multiple actions at various levels (Butterfoss et al., 1993). The members of the coalition itself determine how the vision of creating a healthy community is manifested, and therefore the purpose of the coalition itself depends upon the characteristics of membership.

Membership Criteria and Characteristics. One of the principal components of community development and the Healthy Communities concept is broad public participation in the process (British Columbia Ministry of Health, 1989). Additionally, having an inclusive membership is an important prescript in community development strategies involving small groups cited above (Gastil, 1993). The membership of this coalition may be described as essentially being comprised of individuals who formally represent an organization, such as the Regional Health Authority, the local municipality, or child and welfare services, or who do not formally represent any organization at all. Both may simply have an interest in the health of the community and feel good about contributing to the health of the community.

> "...most of the members have an affiliation with some organization or through the town or through [the Regional Health Authority], that's why, part of why they come...but most of the people are interested in making sure that this is the community that they want to live in..." (11, 441 - 444)

"I believe in supporting your community. I'm interested in the health of a community in general." (05, 507 - 508)

"…it gives me the satisfaction within myself that maybe I'm contributing somewhat to keep the area in a safe environment and a happy environment." (01, 1040 - 1042)

Membership in this coalition is defined by at least three criteria: geographical proximity to the community, interest and willingness to contribute, and existing on the coalition's mailing list.

"[A member is]…anybody that wants to go to the meetings…from what I see anyway, anybody that's within the [community's] area is really a member of the coalition and can go, but you're supposed to be a participating member…you know, be interested and go to the meetings, and not just a citizen…" (03, 154 - 156)

"[A member is] someone with an interest and has shown up and asked to be on the mailing list, somebody who wants to be aware of the issues that are coming to the table, has an expressed desire to contribute to some of them when they have the time and desire." (10, 393 - 397)

"A member of the coalition is somebody who comes to a meeting and then they're placed on the mailing list if they wish to do that…its not like you have to be representing a group or anything like that, any citizen, anybody interested can become a member. (15, 52 - 57).

Being on the coalition's mailing list provides direct access to coalition meeting minutes, and any supplementary information that is included with the minutes. Although the membership of the coalition may be considered relatively large with 50 members at the time this research project began, most of the members may not be considered active in the sense that they attend meetings on a regular basis. Coalition meetings are held twice a month, with breaks during July, August, and December. In fact, out of the 50 members on the mailing list, only 24 members had attended two meetings or more in the 12 months prior to this study beginning, and only 10 of those attended 8 or more of the 19 meetings held in that same 12 month period. However, the relative levels of participation by members of the coalition seems to be accepted, as these respondents commented:

"…I think the group is open minded enough to accept the fact that we're busy people and commitments change…" (04, 427 - 428)

"…not that other people that aren't attending regularly don't have, or aren't thinking of us, or if we really needed their support then we'd have it, I just think of them as people on reserve." (16, 365 - 366)

The relatively small numbers of people who attend meetings on a 'regular' basis have been referred to by interview participants as the "core group" or as "key members":

> "Our roster is very large but our members in attendance are usually what I call hard core, the hard core group of any particular organization, the one that really makes it function, and so there are those people. (14, 15 - 17)

> "…there's a core group in there that attend most of the meetings and listen to these presentations that we get, and reports from ongoing groups and whatever things we're doing and so I think those are the real key members of the coalition…" (16, 362 - 364)

By virtue of the fact that there are "over fifty members, and a very strong core group of over ten people that come, turn out every two weeks for the last two years" (18, 228 - 229), the core group has been described as being particularly committed to the coalition.

> "Well I guess probably what it is is that people just sort of made a commitment to [the coalition] and its its one of their priorities too because to come to something twice a month it means you have to give up other things occasionally and ahm cause there's maybe I think ten, twelve people that are generally there." (11, 175 - 177)

These key members are well connected in the community through either their profession or through other volunteer work they have done in the community. Comments from respondents, supported by observation, that describe the core group include:

> "…members who represent the coalition I would say, were people who have a strong interest in the community. You get the same people there I'm sure that, that are the shakers and the doers." (05, 366 - 369)

> "…you see the real leaders in the community that are involved with lots of different committees and redesigning this and redesigning that, they're the ones that are here constantly…" (02, 245 - 248)

> "we've got other people that have connections and ahm they're networked very well, they sit on lots of the different communities, or lots of the community committees, so ah although they're not the formal legitimizers within the community they have lots of fingers out there, so I think their in touch with the pulse of the community. (18, 291 - 294)

Since these connected coalition members are also from the community at large, there are some expectations about these individuals who wear "different hats" (08, 490) as one respondent described them:

> "…they're a community member and they're part of the coalition, but that they are also going to bring that back to their jobs and hopefully get something done about it to." (08, 515 - 517)

However, the presence of individuals who have a 'dual role' in the coalition is not without its drawbacks, as the same respondent describes:

> "In some ways its important and when you wanna have the different hats on but I think in that way its exclusive in the sense that we could get some other people who are just be it stay at home moms or whatever they are and want to be involved and don't really have to have a title so much, and it could be intimidating maybe a little bit for someone coming like that." (08, 489 - 494)

In addition to the common characteristic of being connected in the community, the core group is also viewed as having similar interests, values, and a shared purpose, as this respondent described:

> "…that core group of people also share a lot of the same values, so they're interested in health and wellness, they're interested in the community, interested in making it better so it's a social thing, but they're also there because they share values and purpose." (15, 221 - 224)

The awareness that there is a core group of individuals who do participate more often in the group is tempered by the realization that there are individuals or groups in the community that may be under represented.

> "...we don't have people who aren't very well connected, we have people who are all very connected and very active so we don't have someone who is, say, living below the poverty line or someone who is retired and in a seniors home or that sort of thing..." (08, 405 - 409)

> "I think there could be a lot more people represented. I I feel ahm that some areas are definitely not being represented, and I know that the coalition feels that way to. You know like the businesses don't seem to be worried about it or or care, or maybe don't understand. Ahm town council is certainly represented and [the Regional Health Authority] is represented in various ways and there's a few other key ah people that that always come out but there seems to be lots of people who are not represented." (02, 70 - 77)

Along with the groups identified by the respondents above, other groups identified by respondents that may be under represented include those that leave the immediate community on a daily basis to go to work, seniors, young people, and young parents.

The presence of the "connected" and "active" members of the coalition and the community has also been viewed in a less than favorable context. Specifically, when these core members of the coalition introduce themselves to new members or visitors at

coalition meetings they often do so by giving they're name followed by the group they are affiliated with (if they are affiliated with one). This behavior has been viewed as having a potentially negative effect as described by this respondent:

> "…it's sort of strange though even when your sitting around the table and everyone says they're names like [the Regional Health Authority], and this and that I mean I just don't think they should…I mean I don't have a community job but I think everyone should just be, you know, around the table as a community partner and, you know, not worry about who you are and who what your representing and that sort of thing." (08, 482 - 489)

The same respondent commented further:

> "…I can't think of anyone coming who…didn't have some sort of professional designation or involvement you know, social work, community work that type of thing. I mean you'd think that might be something we need to work on a little more." (08, 494 - 499)

Another negative aspect of the small number of individuals that acted as the core group cited by one respondent was that:

> "…there seemed to be a group that felt they should be doing everything. At one point I felt that they were taking on too much all at one time. I expressed that

> opinion and the meeting became very quiet, and I said 'don't you think at this stage of the game you should be concentrating on one or two, and not trying to take on 10 or 12 different projects until you become established?'" (03, 21 - 26).

Despite the negative aspects of a membership with a core group of connected individuals, observation supports an additional view, substantiated by this respondent's comments.

> "...with our group...and our contacts we can always get what we have to have done, so its not a negative thing." (16, 287)

For instance, by having members on the coalition who are affiliated with the Regional Health Authority, the local municipality, other community groups, government and non-government organizations, and service clubs, potential partnerships are more likely to form. Projects this coalition has addressed, such as accessible transportation in the community, the initiation of a Safe and Caring Communities project, and the fetal alcohol syndrome project involving the Regional Health Authority, children's and family services, were all facilitated by having connected people as members of the coalition.

Another important observed aspect of having a connected membership is the amount of inside information and resources that are available to the coalition from the organizations the members either work for or represent. Specifically, coalition members who also sit on the municipal council are able to share information, and consult on specific processes involved in policy, by-law, or infrastructure development, or share

some of the current policy or legislative changes currently being debated or considered by council that may be important to coalition projects or the community in general.

Second, as the initiator of the project, the Regional Health Authority has provided expertise and leadership regarding the Healthy Communities concept and processes, and as these respondents describe, are a valuable resource for information.

> "…they have helped in the, in letting the coalition know what some of the problems are, what some of the health issues are within the community…" (01, 485 - 487)

> "…the health authority of necessity has an awful lot of information, and about the community, and about things that can benefit the community and I think it plays an important role in that way. Members of the health authority who are involved in the [coalition] I think they ah play ah key role, and they are, if you like, the acting members of the partnership, the people who are employed by the health authority seem to represent it at coalition meetings because through their full time work they have information about programs that are going on or plans or whatever that are important to discuss at meetings." (06, 200 - 210)

In addition, Regional Health Authority members have been observed accessing the expertise of others in their organization and sharing it with the coalition, as well as sharing information regarding public health and health promotion in both a community and regional context. Examples observed include Regional Health Authority staff

presenting at coalition meetings topics such as fetal alcohol syndrome and the safety evaluation of playground equipment in the community.

Last, the local municipality, primarily thorough its community services arm, has been identified through observation and interview data as particularly supportive. The local municipality has provided a significant amount of in kind resources including places for the coalition to meet, sundry items, and human resources to do much of the background work including compiling and mailing out the agenda and minutes.

> "…the provision of space, computer time, and paper and pencils, that whole stuff that needs to get done in the background is supported by the [municipality]." (17, 323 - 325)

Furthermore, the community services office of this municipality has access to information about grant and funding opportunities, as well as information about, and has contact with, other non-government agencies and service groups in the community. The contribution of these resources, as this respondent put it, "certainly legitimizes the town's commitment to the process." (07, 346).

Member organizations and groups have also gained from their membership in the coalition. Specifically, individuals representing groups are able to take information they have been exposed to back to the organizations they represent that will assist them in planning and other activities. In particular, the Regional Health Authority is viewed as benefiting in very specific ways, as this respondent commented:

> "…I think for the health authority there's kind of a grass roots connection with a group of citizens interested in health is a huge benefit to them so its almost like the coalition could be a focus group for them you know if they had a specific topic they wanted to research that would be a group that they could work with. Certainly its providing wonderful first hand experience and opinions for [the Regional Health Authority]…" (15, 169 - 173)

The value of the experience for other agencies and groups is also reflected by this respondent's comments:

> "I'm able to take some of the learnings that I've experienced from [the coalition] back in a liaison capacity to [my group]." (17, 9 - 10).

Legitimacy and influence in the eyes of the local government is also gained by having a connected membership, as this interview participant commented:

> "…to a certain extent the coalition has got political, but that was only inevitable by the players around the table…what I mean political is that the [coalition] can go to the town council and request a meeting and they will be heard…they are listened to at that level while some other groups may not be…" (12, 141 - 154).

This influence also extends to opportunities to consult with other local government officials that can provide information to the coalition regarding some of its initiatives.

For example, a group of coalition members investigating accessible transportation had the opportunity to consult with the municipal manager about methods to distribute a transportation needs assessment survey, and the opportunity to discuss the possibility of including questions regarding accessible transportation needs in the next municipal census.

The various characteristics of membership identified here, when linked to the purposes of the coalition identified by its members, also relate to those of a partnership framework (Scott & Thurston, 1997). In particular, the sphere of interest of those involved, the unique relationships between members or partners, the distinctive characteristics each partner or member brings, and the type of activities that contribute to the collective vision are reflected in the framework of this coalition. Further, the purpose of the coalition defines how the group intends to act, and the membership provides valuable resources including skills, knowledge, and community connections while both provide the required framework for the coalition to function and perform actions that are intended to contribute to the process of creating a healthy community.

Coalition Function

The functional aspects of the coalition include those actions and influences that demonstrate and impact the process of creating a healthy community in this context. Specifically, these actions and influences include the identification of health related needs and concerns of the community, decisions regarding the priority and type of actions that are required to address an issue or concern, evaluation, and the factors that influence the sustainability of the coalition's actions, and the coalition itself.

Need Identification. This community health coalition has not had the benefit of any formalized identification or assessment process regarding the specific health needs of the community and the population that resides in and around it. Despite the means of a formal need identification, groups are considered empowered when they are in charge of their own affairs and able to set its own agenda (Raeburn & Rootman., 1998). Further, Healthy Community projects are characterized by individuals identifying their own needs and setting their own priorities (British Columbia Ministry of Health, 1989). In place of any formal type of assessment, the coalition has relied on identifying needs using other strategies. Although the specific strategies vary, they primarily depend upon the formal and informal structures in the community that disseminate information.

> "…people find out in a smaller community where the action is and drift towards it, and I think that's been happening with (the coalition)" (17, 110 - 112)

The formal and informal structures the coalition relies on to find out about "where the action is" includes the media, the coalition membership, and other community members. The coalition as a forum or medium for identifying the health related needs of the community from others in the community is in line with what some of the respondents described above as what the purpose of the coalition actually is. Specifically, respondents have described the type of issues and concerns the coalition has addressed as:

"…just the ones that come you know, in the media or you can kind of hear by word of mouth, things that are happening in the town..." (13, 76 - 77)

"…it's a more or less wide open, whoever wants, in the community has a problem, and would like to discuss it with the coalition, can come to any meeting, and they have an open discussion area where you can talk about it…" (01, 334 - 338)

"Well we sort of have a list of running things that sort of pop up in our own lives that we think are relevant as well as in the media is a big one…or sometimes other groups come in to speak to us and then the need developed that way. But to be honest I find that its just been more of a sort of a spur of the moment, these things happen and they tend to work out really well…there's not a lot of established sort of networks and things that I mean there's lots of needs so name an issue and probably there needs to be something done on it kind of thing, you know. Because there isn't a wide social network in terms of shelters, and food banks, and community groups and that sort of thing so I mean if someone says you know fetal alcohol syndrome for example I mean there's lots of work that can be done…" (08, 71 - 93)

"…the actual sort of media and some of those kinds of things have generated discussion and so with that the coalition has sort of said ok well this is something we should be at least be talking about…I think the ideas are generated from within and also driven by other sort of components in the community where they

are saying you know well this is an issue, this is a problem and so therefore its got force for at least discussion if not, you know, something further." (09, 47 - 67)

The coalition members seem to be acutely aware that the identification of need is very dependent upon individual community members or groups, and for that reason are particularly sensitive to ensuring that any concerns that are brought to the coalition are at least listened to, as these respondents described:

"…I'm just not aware that anybody wouldn't be welcome, I'm not aware that anybody has ever been turned away from a forum for listening to an issue. And I think we would listen to them and then if it didn't fit we would be obligated, I would hope, to tell them that or to have them go to another group or another source of reference…or town council rather, that sort of thing." (17, 271 - 275)

"…I don't think its exclusive certainly anybody can just come by who wants to come, they're welcome to join our group, and I would think that most people would feel welcome if they came to our meetings. I don't think they would think they don't want me…" (11, 87 - 89)

Observation of coalition meetings supports the statements made by these respondents. For instance, during the observation period anytime a coalition or a community member had an issue that he or she would like to bring the attention of the coalition an opportunity was provided for the individuals or groups to speak to their

concerns. Opportunities to add items to the agenda at the beginning of meetings, and open discussion during every meeting allow for coalition and community members to introduce new issues or re-visit past concerns. Examples of discussion brought up include wheel chair accessibility around the town, and a potential homeless person whose welfare was of concern to members of the group. Typically items that are added to the agenda at the beginning of meetings include reports from coalition sub-committees or information regarding other health related activities on-going in the community.

Despite the belief by the most of the membership that the existence of the coalition provides the opportunity for community members to identify need, it may only available to those that are aware of the coalition itself, its role in the community, as well as have the ability to attend the meetings. When asked about how one respondent was able to speak about an issue of interest at a coalition meeting the respondent commented:

> "…I'm in the know…but for a community member, I'm not sure they would know…" (05, 98)

Another respondent was certainly aware of the challenges of identifying need for the broader community:

> "…there's also just a feeling in the town, I mean you know sort of the hot points or what's relevant, but again you can't speak for everyone and you have to and I think that's a big thing to, you have to be careful about that because what's right

for say the ten people sitting around the table may not be right for everyone. (08, 382 - 396)

Once a need, or a potential need, has been identified the coalition goes through the process of making a decision about what, if any, action will be taken in attempt to influence or address the concern.

Decision Making. The decision making process may be considered to be the most important functional tasks for a group involved in a community development project and represents a key component of the distribution of power and resources within a group (Butterfoss et al., 1993). Determining what items get on the coalition's agenda, prioritizing the issues to be addressed, and deciding on a course of action are all affected by the coalition's decision making process.

Based upon the coalition's terms of reference, the formal decision making process is consensus. For the most part interview respondents described consensus as the process as the way in which the group makes decisions:

"...in terms of the process of making decisions that is sort of a unanimous sort of decision making thing. People speak their points until sort of a consensus is arrived." (08, 54 - 56)

When asked to describe consensus these respondents commented:

"Consensus in a sense doesn't mean everyone says yeah this is the best idea I wanna do it, but it just says yeah everyone agrees it is a worthwhile project and you go ahead with it. No one is dramatically opposed, I think what consensus means, you know. Because not everyone's going to be this is my top priority, but if someone brings up some negative or some con arguments I guess then chances are you know we'll either put it on the back burner and think about it again that type of thing. So, you won't move if there is someone raising sort of a flap about it basically." (08, 142 - 151)

"…in my experience in the meetings I have been at it's a consensus building process which I like to attribute to being a very feminist process (laughing) but certainly males are capable of coming along with that type of thing. But certainly it looks for not total unanimity, but certainly some recognition of the merits and also some recognition of the points that might be against a process and that is what you need is people in the committee level to argue pro con so that you have the realization of what's happening before you go into addressing an issue." (07, 73 - 82)

Decision making within the coalition using the consensus model described above by respondents is supported by observation data. For example, at one meeting a coalition member introduced an issue of concern of a fellow community member regarding the accessibility of certain areas, businesses, and public buildings to individuals in wheel chairs, and those using strollers or carts. The coalition openly discussed what, if

anything, they could do with or for this community member to assist in attempting to promote changes in the community to improve accessibility. Although it was unclear to some of the members what the coalition might possibly be able to do, the group came to a consensus that they should at least listen what the individual had to say, and share any ideas about possible contacts or steps that might be able to be followed to address this issue. Eventually the individual did attend a coalition meeting to present his concerns, and attempted to raise the profile of the issue within the coalition.

Consensus within the group is also determined using different methods than what have been described above; none of which are used on a consistent basis. For example, at times each of the coalition's co-chairs have been observed making what seem to be unilateral decisions about taking action on a specific issue, or setting the coalition's agenda for the future. Although these decisions seem to be partial, no one member had spoken out against the decisions during meetings despite opportunities to do so. A specific example includes decisions at different times during the observation period to form an ad-hoc or sub-committees to address various issues in the community. In these instances a co-chair made a decision with varying degrees of discussion around the issue itself, and how best the coalition may be able to address it. In these cases it be said that a consensus was reached because the group accepted the decision made by the co-chair without any objection from the rest of the membership. Decisions of this type are not, however, limited to the co-chairs as other members in the coalition have also been observed making similar decisions, often in the form of suggestions, in similar circumstances.

Another alternative form the group uses to determine consensus may be described as a very loose attempt to follow parliamentary procedure. In this scenario a coalition member introduces a need or concern, and then the group discusses it to some extent. At some point during the discussion a member will put a motion forward to either support a given action or inaction, the motion will then be seconded by another coalition member, and then the motion is voted upon by the membership present at the meeting. If the majority (over half the membership present at a meeting) votes for or against a motion, the decision will favor the majority, also called a "working consensus" (Butterfoss et al., 1993, p. 324). This process has been observed when the coalition is making decisions affecting the administrative function of the coalition as an organization, endorsing new projects, and determining if a potential partnership or project fits within the coalition's purpose or mandate.

The reasoning behind the various approaches to consensus as a decision making process is unclear, however one respondent believed that it was the result of having members who had experience on different committees in the community, and that the differences were the result of the different decision making processes within these various committees.

> "A lot of these people serve on other town committees and they're very structured, [Committee X] is a very structured committee and its very formal and so always have motions and voting and this kind of thing, where [the coalition] has been kind of informal, but now we're getting more formal as we go along" (14, 101 - 105)

In some of the most interesting circumstances during the observation period, a consensus seemed to be arrived at intuitively within the coalition membership when deciding to take on a new project, forming a new partnership, or endorsing others' projects. This method of decision making may simply be the result of the level of interest in the issue by the membership present at the meeting when the issue is brought up, as this respondent described:

> "…it's the interest of the people who are present that drives some of [the projects] forward…" (11, 277)

In such cases issues may receive only a limited amount of discussion about if or how the coalition will address it. For example, during the observation period the community was faced with the removal of several pieces of playground equipment due to it not meeting national safety standards. The Regional Health Authority provided a brief presentation to the coalition on how the playgrounds were measured to determine if they met the standards, described that a great number, if not all, of the playgrounds in the community were non-compliant, along with some hospital emergency room utilization statistics that were associated with playgrounds use. Despite this issue being important enough to bring to the coalition's attention, the potential consequences of leaving unsafe playground equipment in place, or the impact of removing much of the playground equipment upon the community, there was very little discussion, and no apparent decision about how the coalition could, or if it actually would address the issue. This particular issue was only

brought up this one time during the observation period. Also of interest in this case was the fact that almost, if not all of the coalition members present at that meeting did not have any small children of their own.

Alternatively, issues may receive a great amount of attention from the membership present at a meeting. For example, at one of the meetings toward the end of the observation period the coalition had discussed how a decision had been made to first support a grant proposal being submitted by the coalition on behalf of the local municipality, later reject it, and then support it again. As it was described during the meeting the issue only received the attention it did because of the interest members in attendance at that specific meeting had. The comments of these respondents support the observation that the members in attendance have a dynamic effect upon the decision making process:

> "I think it's it just depends on people who are attending and what they think about at that time, so and you know we've certainly also seen it change, where we've had one meeting where people have been really supportive and then the next meeting where someone different might be attending and might say 'now just a minute there is that really what we want to do, are we sure, what are we getting into?' And we have changed our minds, we've backed off, we've looked at things, ah again so it does very much depend on the people attending the meeting when the item is on the agenda." (15, 80 - 86)

> "Well I think the process is trying to create a consensus around what should be done, ah often the same people aren't at the table that's difficult to do when different faces appear from time to time..." (17, 78 - 80)

Decisions are also based upon human resource availability, as one respondent put it "Possibly a man power allocation, availability issue..." (10, 132), or as these respondents described based upon the capacity and desire of the coalition or its members to act on an issue:

> "...some of it's the circumstances of what comes up, like if it if there looks like a role we can play in it and there are people who want to do it, then I think those are probably sort of the deciding things." (11, 268 - 269)

> "Sometimes the decision's just because somebody goes 'yeah that's I'll do that, that's something that I know about, that I want to do, and yup that's me', and other times we've sort of thought ok we need a sub-committee does anybody want to be on it...some people may say 'yup I think that's a good idea but I'm not going to do that right now', or 'you know it could be better if we did that later' and it doesn't mean you know it doesn't mean that the coalition doesn't back it..." (11, 122 - 128)

Another respondent described how decisions may be based upon the availability of financial resources:

"…We don't have the funds to do anything…other than to say 'Ok, this needs to be done'…?" (13, 106).

In response to how the relative lack of financial resources have affected the decisions the coalition has made to address or influence specific issues, the coalition was observed going through the process of becoming registered under the Societies Act in the province. By becoming a registered society the coalition is hoping that they will be able to access grant and other funding opportunities available to non-profit groups.

Although, there is no information, from interviews or observation, to suggest that people do not feel comfortable in challenging the decision making process, two respondents expressed some level of discomfort in certain aspects of the process overall. First, one respondent described a low level of comfort in the amount of expertise individual members of the coalition had who were making decisions that may have an effect upon the entire community.

"…there's a group of 10 or 15 people that are making decisions and maybe without the right background to be making those decisions and people get all fired up…I mean lots of stuff they're doing is great…I just worry about that because I don't think they really know, have enough expertise to be making those kinda decisions. (02, 26 - 37)

Second, another respondent described a very different process about the decision making process and felt that decisions were made:

> "…by the stronger members of the group, the ones who are vocal, and that's a danger actually because you're not listening to those who are quiet." (05, 338 - 340).

Not withstanding these two statements, there is very little evidence to suggest that others in the coalition have the same feelings about the various aspects of the decision making process or that this is the typical behavior. However, these statements also challenge the importance within a community development framework for decision-making power to be equally distributed among the members involved in a small group in this context (Gastil, 1993)

Thus, if adequate interest and resources, either human, financial, or both, are available to address a specific issue, and the need fits one of the various purposes of the coalition identified above, a decision is made to take specific action and mobilize resources. Otherwise, the issue or need will be tabled by the group either formally, by specifically taking note to ensure it ends up on the agenda in the future, or informally where it is dropped by the members altogether.

Action and Mobilization. Resources, particularly human, are mobilized by this coalition both formally and informally. Informally, the network of individuals resulting from the formation of the coalition provides opportunities for further networking and collaboration to address health related issues in the community. This relatively informal

method of organizing community members tends to be a simple process, as this respondent describes:

> "…very much a brainstorming approach, somebody raises an issue, somebody else knows something about it, somebody else knows somebody whose interested in it and I think come together or get organized that way." (06, 136 - 139).

This approach has been observed when the coalition has dealt with relatively modest issues, such as developing alternative ways to communicate the coalition's activities to the rest of the community. For example, the development of a web site as a communication tool has led to the identification of other members in the community that would be willing to assist. Another instance where this was observed was during discussion around opportunities to address family violence prevention month and raise awareness of violence in a general sense in the community. In this case, community members were identified as potential writers of articles about family violence for the local newspaper.

On the other hand, the coalition formally organizes and mobilizes resources through sub-committees, which may be described as the functional unit of the coalition. When a decision to act on a specific issue has been made, and a relationship is formed between two or more existing members, between a coalition member and non-coalition community member, or between the coalition and another group, an ad hoc, or sub-committee is formed.

> "...an issue is raised because perhaps an individual member has concerns and then we discuss it as a group at the meeting and from that discussion there is then the impetus to organize a sub-committee, that's definitely what happened with the youth forum and the transport [issue]...then through sub-committee organizations you can involve people from other associations who may not want to perhaps commit to full time attendance or whatever...but are interested in single issues and come to join for that particular issue...(06, 118 - 133).

Sub-committee formation depends heavily upon the decision making process described above, particularly with respect to human resources and interest within the membership. For example at times during the observation period when it has been decided that a sub-committee should be formed to gather information, put together a plan, or take specific steps toward an objective, the formation of the sub-committee is contingent upon a volunteer effort from the membership who are not always quick to come forward. However, enough coalition members do eventually step forward for the sub-committee to address the issue at a minimal level of functioning. Thus, sub-committees provide those members of the coalition with an interest in a specific issue, or others in the community with a related concern, to become engaged in the process of creating a healthy community.

> "...the group is pretty astute at looking around and saying 'now is this an issue that interests everybody, or is this just a program or a project that interests two or three people', so you know I mean we won't have people coming to the meetings

forever if we're talking about things they're not interested in, so some of those things we have to divide out..." (15, 310 - 305)

"The sub-committees that exist I think are there to bring together people who have a specific interest on a topic that might not be shared by every member of the coalition. So it's almost like a little interest group that says 'hey I'll look at transportation', and a couple of other people say 'yeah, that's an interest I have, let's look at that' and do the leg work, the in-depth work, but then bring it back to the group and say 'ok is this something the group can support...'" (04, 262 - 269)

"...it's just when you have a special pet interest you get to kind of do the job. Which is fine, you know, if you've got the interest in it then your probably going to do a better job than somebody who isn't." (13, 313 - 315)

"...through sub-committee organizations you can involve people from other associations who may not want to perhaps commit to full time attendance or whatever...but are interested in single issues and come to join for that particular issue...(06, 118 - 133).

"We try and pull in other people from the community too with the sub-groups. Ahm the media has been a part of a lot of the different sub-groups, ahm schools, ahm police, depending on the nature of the issue we try and get other pieces of the community involved and that's one way of reaching out more to the community

> so it's not an exclusive group…quite often in discussions the group will say well who needs to be involved, who needs to be informed of this, who needs to be at this table, and ah then they that's usually when they say 'well you know we'll form a sub-committee and then pull in these other players.'" (18, 424 - 435).

Engaging 'non-members' or other community members through sub-committees is certainly supported by observational data. For example, the transportation sub-committee held a public forum to not only gather information about the various concerns regarding accessible transportation in the community, but was also successful in recruiting other members from the community to join them in addressing the issue. The youth forum sub-committee was also successful in recruiting youth community members from outside the coalition to address the issues that were affecting them, some of whom became coalition members. In fact, one respondent commented that without the youth involvement the entire project would just not have occurred the way it did:

> "Now the youth forums that we did, there's a good example there, where we involved young people and helped to train them to be facilitators to go out and help us with that project. That project would have been nothing without that, I mean if we had said 'Ok four people from the coalition are going to get together and they're going to make up these questions and visit these classes', that wouldn't have worked at all compared to the way it worked by getting high school students to go and do that. So there's an example where we reached out and we got other people involved in a specific project." (15, 264 - 270)

Evaluation research carried out on other Healthy Communities projects have found similar results when looking at patterns of member activity. In particular citizens tend to get involved in issues that affect them directly, only when there is a hint of a solution to the problem, or when they feel empowered (Oullet et al, 1994).

Specific actions that a sub-committee may take have been described by interviewees or observed during the research period include organizing and mobilizing resources in the community to disseminate information, work on projects with tangible or intangible outcomes, or involve attempting to access resources outside the immediate community including grant monies or expertise. Respondents have also described sub-committees as a method to gather more information about a particular issue before the coalition will endorse or support a specific project in the community, or make decisions about further potential actions regarding a specific community health related need that had been identified.

> "…it's probably an effective way of looking at issues in some depth, looking at where the support might be, but bring that back and say 'ok here's what we've done, here's our report back to you, what's your direction as to where we go?'" (07, 285 - 289).

> "…what they do then is bring the report back to the committee and then a decision is made do we do it or don't we do it, is it good for the community, is someone else doing it, or is this our mandate…" (14, 167 - 168).

All of these actions may ultimately result in the coalition meeting or fulfilling its purpose as described by the members, or on a broader scale attempt to fulfill the vision of creating a healthy community.

Specific examples of sub-committees that have been mentioned during interviews, discussed during coalition meetings, or observed during the course of this research include those that have worked to organize and host an information session on fetal alcohol syndrome, recruited and trained youth facilitators used to gather opinions in response to a youth curfew by-law, gathered information and resources to support accessible transportation in the community, brought in a speaker on organizational development in the community context, and accessed funding available through grants for a community garden.

Sub-committees work relatively independently from the main coalition group. Basic plans of action, or inaction, as well as decisions about information gathering techniques have been observed being developed during sub-committee meetings. As these respondents describe, there are benefits of having independent sub-committees address specific issues.

> "...it helps out the overall running of the committee I think, it runs a little smoother if we can break things down into finite parts, so therefore rather than ten or twelve of us sitting around the table discussing transportation, well that will be divided into a sub-committee, where they may end up with six or seven on that committee, they will meet separately discuss the problem and then bring it back to the main committee." (14, 150 - 154)

"Well because everybody can't do whatever, it usually only takes a couple of people, and as this goes on I mean we can't have everybody doing everything you got to divide it up somehow so, also personal interest and that makes it the easiest way to carry forward is if you take something yeah this is something I want to do then your going to do it and then you can report back and say and not you know everybody needs to be on every committee to get stuff done, a smaller number of people is optimal sometimes." (11, 609 - 623)

"…(sub-committees) seems to me to be an effective way of working because that way meetings don't get bogged down with single issues you deal with several things in a meeting because you've got sub-committees at other times working on them and so general meetings are an opportunity for the sub-committee to report and update…" (06 123 - 128)

Although the sub-committees do work relatively independently, each report to the coalition as a whole. These reports, as the respondents above have described them, typically consist of any progress, challenges and successes the group has realized, or the resources (or lack of) that have helped (or limited) the group's progress to date. The relationship between the sub-committees and the coalition is positive in the sense that the coalition also acts in advisory capacity to the sub-committee, as well as providing other vital information about process or other resources in the community, or just plain moral support, as these respondents describe:

"…they essentially do their thing somewhat independently and report back, but I mean no decisions are made without sort of, like we wouldn't go off on a whole separate branch without the coalition…" (08, 107 - 110).

"…I see it as a working group, individual but we will report back to the coalition because I think its just good policy to do that and, and they may be able to help and advise us…(05, 266 - 269).

"…the sub-committee comes back to report at meetings and I see that definitely being the link that they, whatever they're doing, they're not on their own, they still have involvement in the coalition and what they're doing is part of the coalition's umbrella…it benefits both parties. It doesn't mean that the people who of sub-committee's are just sent off on their own to deal with the issue once it been raised they handle it, it's not that sort of approach at all…they're not off on their own, there's constant continual interaction, feedback and reporting with the main coalition and I think that's fundamental because it's the general approach of the coalition…" (06 149 - 165)

"…to celebrate if an outcome has been achieved, to report back to the group as a whole so the group can have ownership of the issue, address any concerns that might be arising." (17, 386 - 389)

The coalition membership has also been observed providing positive feedback to sub-committees, as well as recognition. In one particular occurrence the coalition membership congratulated and celebrated the efforts of the accessible transportation sub-committee for its ability to formulate specific goals in attempting to resolve the accessible transportation dilemmas in the community. Something as simple as that was viewed by a few in the sub-committee as a relatively minor accomplishment, however others in the coalition treated it as a major success.

Once informal or formal action has been taken by the coalition in an attempt to influence a specific health related issue relevant to the social or physical environment of the community, steps are taken to determine the impact of the coalition's efforts on the ultimate outcome of creating a healthy community.

Evaluation. Along with a lack of what any policy maker, researcher, or academic would call a formal needs assessment is the lack of any formal evaluation practices, plan, or strategy. Interview respondents describe very simple processes used to determine the outcomes, or the value of the coalition's efforts in attempting to influence certain health related issues in the community. First, the coalition does spend time reflecting upon the work that has been done during the previous year.

> "We don't have a lot of like check check process in place where I know at work you have all these quarterly reviews and everything like that, we don't have anything like that. But I know, like I said I've only been here a year myself, but I mean at the new year, assuming last year, I think the first one in '98 was sort of a look back at what's happened as well as projected goals again. So in a way I

guess that's essentially what we're doing and how we're meeting our goals. (08, 216 - 223).

During the data collection period the coalition was observed preparing for their annual meeting where goals are set for the upcoming year, and the successes and challenges of the previous year are reviewed.

Another strategy the interview respondents described as a method of determining the impact of their efforts were having upon the community was by gauging the community's response to the events, activities, or projects the coalition was undertaking or had been involved in.

"…you know by the responses you're getting back from the community…I'm not sure exactly what they call it now, what they did with the teens with the schools…I think by the response that you did get from the school…the involvement you got from [the teens], and same with the seniors walk, the involvement, there were a lot of seniors that turned out…I think the involvement that you get from the community is letting you know that you are doing something for the community." (01, 412 - 422).

"…I am not sure that, you know, there is any data or statistics, that kind of thing yet, much other than you know maybe attendance at different things and certainly the participation of the youth groups, they were pleased with the numbers of the

young people who wanted to go through the questions, sort of interviewing phase of things…" (09, 163 - 169).

"…we started very early, I'd say practically in the first six months of the coalition, looking into fetal alcohol syndrome. We gathered information, we had a little a, sort of a seminar, forum or a presentation, it wasn't well attended but at least we were thinking about it, it was in the coalition's mind…" (16, 15 - 19)

Using community response to gauge impact certainly seems to be only a short term strategy as one respondent in the coalition was keenly aware of the long period of time it will take before any outcomes of the coalition's efforts have been realized:

"…if you have a philosophy like that your not going to get immediate rewards, and you know your sort of having your rewards down the road, you may not even see them when you look back ten years down the road." (16, 416 - 418)

However, the same respondent commented further, appreciative of the ability of the group to be able to only influence as much as it has:

"…ok our impact on the community hasn't been really realized ok…we haven't expanded enough to embrace the whole community yet, I don't think, and only because we're you know we can only be, do so much ok. But ah I think and we're sort of growing along with the community…" (16, 445 - 448)

The coalition also determines the value of their efforts by trial and error during the course of a project as a method of determining the success of a project, or part of a project.

> "…I mean, a big example of this would be the youth forum I mean its sort of stalled and no one knows really what direction its kind of going in and I mean I think that's sort of how we're checking out things are working I mean right now we've tried a number of ways of getting the youth forum together, not the youth forum but the aftermath of the youth forum, what do we do with it now. And the check, how we know clearly its not working by trying what we wanted to do and its just coming up against a brick wall so you got to try something else or either put the issue to rest then eventually." (08, 216 - 232)

Another respondent looked inward, and described the mere existence of the coalition, the number of members, and the pride the group had as measures of its success:

> "…so you have you have two pieces when your looking at success…the outcomes of the activities of the coalition, but then you also have the coalition itself, and I think that we, you know, when we sit down and say 'Ok we've now been together two years, we have over fifty members, and a very strong core group of over ten people that come, turn out every two weeks for the last two years. I think that the group, and you know I'm giving my own personal opinion, but I think that is an

> indicator of success and I think the group feels that way, there's real pride when we got our t-shirts, when we got our logo, when there's an article in the [newspaper] about the [coalition]…there's a real pride in ownership and when you see these, when you see the coalition members come to a meeting and they've got their little t-shirts on, I mean that's pride, and I think that's another indicator of success. (18, 225 - 236)

One interview participant wasn't quite sure of what the coalition had achieved, but felt that it had least identified and addressed some of the priorities in the community:

> "…so what do we do, I mean, I mean it can be little, to me, I'm not sure whether its really doing anything. I mean maybe all those issues would be addressed somewhere sometime, but there ahm there looking at the needs, the concerns now and saying this is what we see as priorities, speeding up the process maybe." (02, 171 -176)

One challenge in evaluation of Healthy Community projects is that definitions of success may vary over time or between communities (Poland, 1996b), or the context or situation changes resulting in a redundant outcome evaluation tool. In this context key indicators identified by the respondents and observation may include the development of local leadership for community health, community support or response, and the endorsement of the local government.

Sustainability. The ability of the coalition to not only sustain the informal and formal actions it takes over time to address issues, but also the ability of the coalition to sustain itself as an organization, is an important issue identified through observation and corroborated by interview respondents. More specifically, not only do the amount of human and financial resources affect the short-term initiatives that the coalition sub-committees initiate, but also affect the long-term ability of the coalition to endure as an organization.

The effect of having a relatively small core group of individuals consistently participating in meetings and taking on responsibilities in sub-committees has been identified as a concern as these respondents described:

> "…it's still the same core group of people that have been there from the beginning, and whether we need to draw ah some more new people in because every time we sit down and say 'here's a really good project, whose going to do this' and I don't think I can take on anymore right now that's probably my share…" (11, 58 - 61).

> "…we're starting to get a little smaller than we were, at times there seemed to be more people around the table and more availability of individuals to volunteer to do things. So we have to take a check on that I think and reassess ah its fine to say well anybody can join [the coalition] and anybody can come anytime they want, but when there's a list of work to be done and things to get done, we need

> horses there, we need people to volunteer to ah give more of their time. (17, 339 - 344)

A couple of respondents even went far enough to explain that if it wasn't for the core group, the future of the coalition would be in question, or might not even exist:

> "I would think that if they weren't there, it would probably disappear, so it's get more of an understanding after you've gone to a couple of meetings, you know these people are vital to it." (01, 102 - 105)

> "Yeah, but I mean it's a small core group of people that's carrying forward from meeting to meeting, if we were all to die off or something I don't know what would happen." (11, 566 - 567)

Potential reasons for the limited number of participants in the coalition identified by respondents include the time commitment required to address issues, dealing with government "red tape" (02, 446), and the lack of knowledge of the coalition and its function in the greater community as these respondents described:

> "The one thing that I found out…is that nobody ever seems to have ever heard of the [the coalition] in town cause I've asked all kinds of people, 'have you heard?'" (14, 212 - 214)

"…I still talk to people now who have no idea what the [coalition] is, so obviously the things we're doing aren't quite getting out there and the newspaper would be probably the main venue that we use now. Well not everyone reads the newspaper or they wouldn't necessarily read and lots of times when we put articles in there fairly ahm fairly ahm broad and like they don't they wouldn't necessarily appeal to everybody you know like if you already knew something about it you might read it but if you didn't so that to me is one of the things that we need to do a little more work on so that people know that we're there…" (11, 74 - 79)

"I think one of the difficulties is that the work of the coalition is so broad that the name is very broad, and so some people might think that its not specific, its not to do with what I'm doing and ah people might hear about the coalition and then think it doesn't apply to them…" (06, 341 - 346)

This disappointment these coalition members have about the lack of knowledge of such projects among the greater population of other communities is not uncommon, and has been identified in other Healthy Community projects that have been evaluated (Oullet et. al, 1994).

Observation data supports the concern that time commitment affects participation in coalition activities. It was noted that at times it was difficult for one particular sub-committee to meet to address specifics and plan for future initiatives due to time constraints and other commitments of the sub-committee members. Also, during

observation of the same sub-committee, members were also having a difficult time generating enough interest in the greater community to justify continuing their efforts. Although the members were clearly frustrated they did not diminish the importance of the issue in the larger context of the entire community, and vowed that they would continue the project despite this barrier.

Financial resources have also been identified as an issue that affects the coalition's long term ability to influence the health related concerns of the community.

> "…I think there are a lot of clear ideas on what can be done, what needs to be done and what needs looking at, and the funding is the big barrier to all of that. Ah not necessarily a barrier but a project has to measured in, you know, not in terms of what needs doing but with this money or with this funding what can we do?…we've been fortunate in that the daily, just pure administration of the coalition, has funding and so that that doesn't seem to be a concern. Ahm but it's for major projects like the community garden and things where funding had to be sought from elsewhere, and they're currently in course of applying for lottery funding…I can't see why we shouldn't get it you know, I hope that the people accepting applications will be able to see what important work we're doing, but ah I think we're fortunate in that members of the coalition…have a very good idea where to go to get funding ahm and and what's available…." (06, 254 - 273).

> "…I think we're at the point now where we want to do some bigger projects, like fetal alcoholism is big spoonful and ah, there's other parts, the community garden

> is going to be more, you know, buy fancy materials…gonna need more than grants to do stuff like that." (12, 505 - 509).

The need for economic resources has been found to be an influential factor for the development of Healthy Community projects in other contexts (Nuñez, Colomer, Peiro, & Alvarz-Dardet, 1994). As described here previously, in an attempt to generate funding the coalition had been observed going through the process of becoming registered under the province's Societies Act which would allow them to access a greater number of opportunities and options to generate monies to conduct their activities. In addition, respondents identified that funding for a paid position that would be of real benefit, particularly as it could free up volunteer time and energy.

> "…its growing and its become a lot of work, and it would be really nice to have a part time person that you could, they could do that kind of background work because it's significant, that's a significant amount of work and it influences the success of the Coalition." (18, 482 - 484)

> "…I think as you get bigger you want to do bigger projects and you can't just rely on volunteers, you gotta rely on paid professional staff and that's where money always becomes an issue." (14, 509 - 512)

> "…I believe that in order for it to sustain itself there's going to have to be some paid representation to provide continuity because I think that these people who

> um are able and have been giving ah as much as their time and energy up to date as they have will eventually run out of gas…You have to have somebody who that's their role and responsibility that's what their being paid for…then that sort of allows the other people if they need to stand back and take a breath for awhile to be able to do that and also um have the coalition continue. (09, 96 - 108)

The coalition's ability to sustain its informal and formal actions affect the long term sustainability of the coalition itself by its ability to fulfill its purpose, and ultimately influence the factors that affect the health of the community. This ability is linked closely to the amount of resources, both human and financial, that are available within the coalition itself, or within or outside of the immediate community. Institutionalization is the last stage that exists in a coalition's formation, and ensures long term, sustainable activity (Butterfoss et al., 1993). Steps this coalition has taken to secure longer term funding, and its relationship with local government, may in fact prove to bring this coalition closer to that stage in its development.

Chapter 5

Summary of Conceptualizations and Conclusion

Although the various components of both the framework and function of the community health coalition were described as being somewhat mutually exclusive, the process of creating a healthy community in this context is characterized by the interaction and interrelationship among the various components. Only by putting the components side by side in relation to each other can the process be fully comprehended, and the the question "What is the process of creating a healthy community in a rural setting" may be answered. A conceptual model that illustrates the interrelationships between the organizational framework and the functional aspects of a community health coalition represents the process of creating a healthy community in this context (Figure 1). The framework for creating a healthy community provides a reference point which guides the functional aspects of the coalition, defined by the steps, events, and key decision points required to influence the various factors, issues, or concerns that affect the health of the community.

The process of creating a healthy community in this context is driven by a community health coalition with a vision of a healthy community. The vision provides the basis for the purpose of the coalition, and meaning for the membership, and although the purpose of the coalition is ultimately determined and interpreted by the membership, the purpose of the coalition influences how the members conduct activities. Coalition members are driven by an interest in the health related issues that either affect the members directly or indirectly at a personal or professional level, or are believed to serve the broader public interest or the community as a whole. These interests, however,

should not be considered restrictive. Since members may be representing themselves, an organization, or believe that they are representing

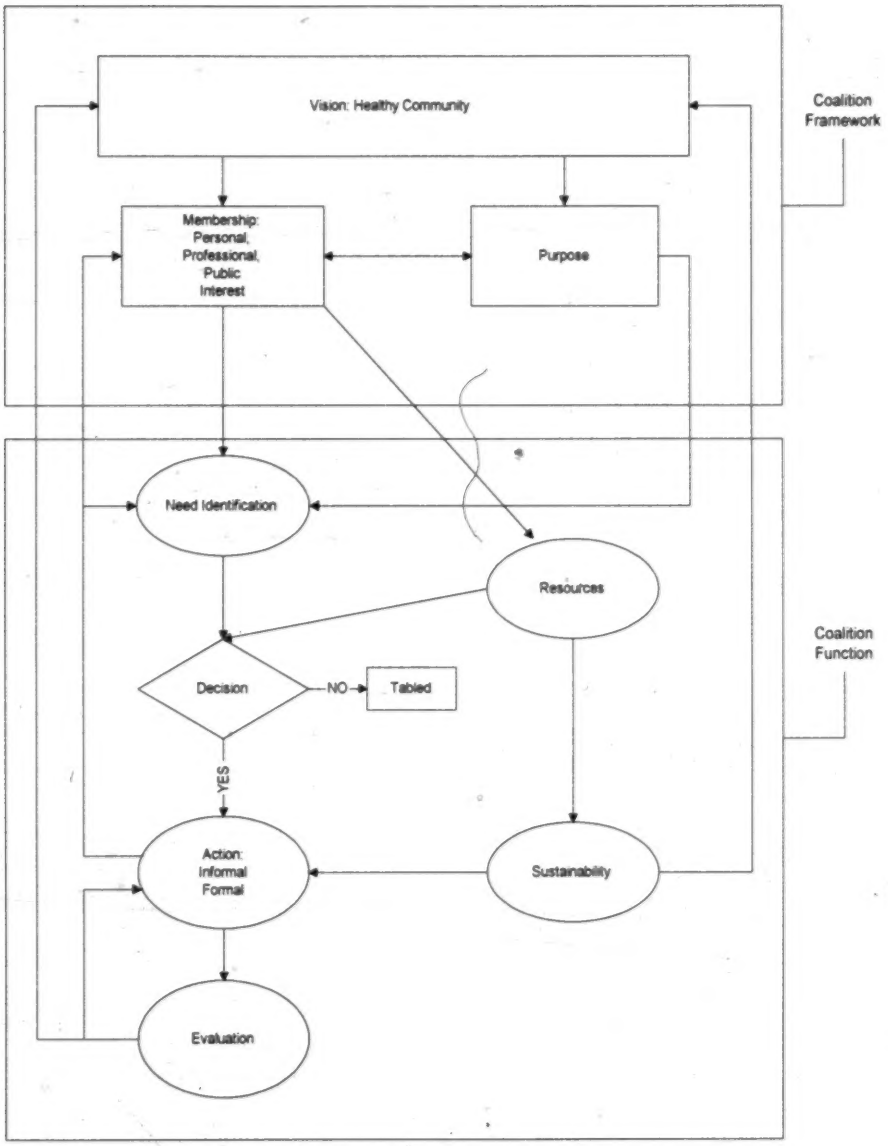

Figure 1. Conceptual model of creating a healthy community.

the entire community at any one time, their interest in a particular health related concern or issue will vary depending upon the role they are assuming. For instance, a member may have a personal interest in an issue that may also be in the interest of the public, or a member who represents a group or agency may have a professional interest in specific issues that may also be of personal interest and vice versa.

The identification of community health-related needs, concerns and issues is the first functional step the coalition takes in order to create a healthy community. Without the benefit of any formalized, community wide health assessment the coalition defines need based upon personal, professional, and what they believe to be in the public interest. Coalition members also identify need using the local media and input from non-coalition community members. The needs identified reflect what is required in order to realize the vision of creating a healthy community, and fit within the purpose of the coalition.

Once a need, issue, or concern has been identified, the decision to take action and mobilize resources to address the identified concern is made by consensus. These decisions are influenced by the amount of both human and financial resources that are available. The human resource base is the coalition's membership, as well as non-coalition community members who may be affiliated with any of the organizations that are represented by members of the coalition. Financial and in kind resources may be provided by organizations represented, or acquired through application to available grants. If the coalition decides that current resource levels inhibit action, member interest is low, or the issue or concern does not fit within the coalition's mandate, the issue will be tabled. Alternatively, if there is interest in the membership of the coalition, its members determine that all the resources necessary are available or can be obtained, and

the coalition feels its actions can have a positively influence the issue, resources will be mobilized.

Resource mobilization may be informal or formal in nature. Informal actions typically require fewer resources and either address relatively simple issues, or take a small step towards attempting to influence a large health related concern. Formal actions by the coalition result from the formation of a sub-committee to address a specific health related concern. Activities that the sub-committees undertake may include gathering more information that will be used to clarify need in order to make further decisions about potential future actions, or may have their own outcomes, both intangible or tangible. Both informal and formal actions may include non-coalition community members when available or deemed necessary. Non-coalition community members may become members of the coalition as a result of their involvement in informal and formal actions.

Without the benefit of any formalized process or outcome evaluation strategy the coalition evaluates its actions by considering the community's response, trial and error, and matching outcomes with previously set goals. The coalition's evaluation of its own actions consider the short term impact, as well as the longer term outcome in relation to the vision of creating a healthy community.

The sustainability of the coalition's activities, and on a larger scale the coalition itself, is dependent upon the amount of human and financial resources that are available to it. The amount of resources affect the coalition by influencing the distribution of work between the members of the coalition and the financial commitment made and required to sustain the efforts of the coalition's activities. The purpose of the coalition in the long

term, and its vision of creating a healthy community, is also impacted by both the short and long term accessibility of resources.

Community and coalition member interest are two factors that play an important and influential role in the aspects that make up the coalition's overall framework and function. Community interest in the community health coalition and its vision will influence the number and type of individuals and groups who will constitute its membership. While coalition member interest essentially determines which health related issues or concerns are identified at coalition meetings, action depends upon the level or amount of human resources which are available to form sub-committees, and the willingness to provide or acquire financial resources to support specific actions initiated by the group. Interest in this sense may be considered to be a function of the willingness to act and dependent upon the available infrastructure (Pearson, Bales, Blair, Emmanuel, Farquhar, Low, MacGregor, MacLean, O'Connor, Pardell, & Petrasovits, 1998), including skills and knowledge, within both the community and the coalition itself.

Revisiting the factors that contribute to the maintenance of coalitions outlined by Butterfoss et al. (1993) provides an opportunity to develop a conceptual context for this community health coalition. First, the level of formalization within this coalition varies. The coalition's terms of reference provide it with specific rules regarding membership, meeting procedures, the decision making process, communication, and the coalition's purpose. However, as demonstrated, the coalition does not necessarily conform to the terms, and is flexible enough to take advantage of opportunities where conformity to the terms may stifle creativity and limit change. Second, the leadership of coalitions in general tends to be from core members who dominate coalition activities (Roberts-

DeGennaro, 1986b as cited in Butterfoss et al., 1993), and this coalition is no different. Third, the coalition's membership is its greatest asset as each member brings a different set of resources and skills to the coalition. Diversity within the membership, various skills, and community connections are cited as vital to coalition function, and although the coalition is weighted heavily in some of these characteristics of membership, the coalition recognizes its shortcomings. Fourth, a coalition's organizational climate is dependent upon the relationships between its members, communication patterns, and its decision making and problem solving processes. Although difficult to assess using the tools used for this research the organizational climate of this coalition certainly seems to be positive. The interaction between members during the observation period, the formal communication methods (agendas, meetings, and minutes), using a consensus process to make decisions, and the formal and informal strategies to solve health related problems in this community result in a climate where the coalition makes constructive attempts to create a healthy community. Last, this coalition's relationship with its external supports, mainly the Regional Health Authority and the local municipality, provide in kind resources to effectively function at a minimum level, as well as the skills and expertise that contribute to the vision of creating a healthy community in this context.

The one characteristic about the process occurring in a rural setting identified by respondents was the accessibility of the local municipality, particularly expertise within various departments and at the municipal council level. Respondents themselves questioned the availability of municipal officials within an urban setting.

The answer to the second research question, "What is the role of both local government and the Regional Health Authority in the process of creating a healthy

community in this context?" may be addressed by summarizing each of these groups' actions as described by interview respondents and observed by the investigator. The Healthy City/Community concept has been viewed as a "vehicle for health promotion" (p. 7) from the time of its inception where the involvement of the local government distinguishes this approach from other community health development strategies (Hancock et al., 1993a). Both the local municipality and the Regional Health Authority have demonstrated a role that is supportive of this coalition by providing infrastructure and resources to assist individual community members and groups engage in the process of creating a healthy community. Although political support is viewed as imperative in such projects (Nuñez et al., 1994), the local government has not, at least visibly, imposed its own will upon the coalition or its activities. Further, despite the fact that this coalition was, in a sense, institutionally-created (Labonté, 1993b) through the partnership of the local municipality and the Regional Health Authority, health and other professionals have not defined health problems or developed the strategies to solve the problems. The coalition's focus on building collaborative relationships (Chalmers & Bramadat, 1996) and "inter-agency networking" (Butterfoss et al., 1993, p. 343) within the community reflects the adherence to the principles of multi-sectoral action where attempts have been made to build community capacity, and at times influence public policy and provide an opportunity for broad public participation (Poland, 1996b). In addition this process, as it has been described in this context, represents a distinctive approach to developing local solutions to local health related concerns and needs (Hayes & Willms, 1990).

The last question that guided this research, "Has the process of creating a healthy community in this context been implemented as intended, particularly with respect to the

fundamental values and principles of health promotion, empowerment, and community development?" may be answered by considering the actions of both the coalition as an organization, as well as the actions and statements made by individual members of the coalition itself. First this project demonstrates an opportunity for individuals in a community of interest and geographic proximity to become involved in a process that mobilizes community resources to influence locally identified community health related concerns and issues. However, despite the belief that the coalition provides an environment conducive to broad public participation within the process, the coalition members, by their own admission, are aware that this principle has not yet been realized. The lack of participation by 'marginalized' groups including single mothers, seniors, and others were specifically noted by the members of the group. Nevertheless, coalition members have entered into a process where they have been afforded the opportunity to participate in a process introduced and supported by both the local municipality and the Regional Health Authority. In addition, although local government does play a prominent role within the process, domination at a professional level has not been observed or identified by respondents. Furthermore, the involvement of individual coalition members has been demonstrated to be at a level that reflects individual and organizational control and empowerment at each stage of the process, even to the point where the group has creatively identified alternative methods of accessing scarce financial resources.

Conclusion

The practice of health promotion may be viewed as a process whereby communities are strengthened through community development initiatives that focus on

empowerment as a legitimate method of enabling individuals and groups to influence the factors that affect their health. One application of this process includes Healthy Communities projects that draw on the skills and knowledge of all community members, including the local government, grass roots leaders, and everyday citizens. The experiences of members of a community health coalition, and observation of coalition meetings, have provided the foundation for understanding the process of creating a healthy community in a rural context.

Therefore, in conclusion one can say that the application of the Healthy Communities concept in this context is one that promotes health by striving to conform to the principles and practices of community development, empowerment, and small group development. Specifically, the project encourages and invites broad public participation to identify the health-related needs of the community, and to plan, implement, and evaluate local solutions to those problems. Further, the role of local government demonstrated by the Regional Health Authority and the local municipality has been one of support rather than political or professional domination. Last, the application of the process demonstrated both the challenges of implementing the project, as well as the factors that facilitate knowledge and skill development in the members of the community at large.

Chapter 6

Implications for Future Health Promotion Practice and Research

Both the process and outcomes of conducting this study has identified implications for future health promotion practice and research at the community level.

1. The role of Regional Health Authorities and municipalities as a leader by introducing, facilitating, and supporting the Healthy Communities concept in rural areas necessitates the need for specific skills and knowledge. Specifically, knowledge of the principles and values of health promotion, community development, and the Healthy Communities concept should be required of all health authorities if such health promotion practices are to be implemented as intended and with maximum impact. Research directed at determining the current skill and knowledge levels in Regional Health Authorities, and appropriate measures to increase these levels to an appropriate level would assist in the development of organizations that are capable of planning, implementing, and evaluating sound health promotion strategies.

2. Health promotion practitioners and researchers need to be able to determine the 'state of readiness' of a community when implementing community development/Healthy Communities projects. This recommendation is derived from the fact that, in this context, the principle of broad participation within the process had not yet been achieved. By conducting research into determining what constitutes different levels of a state of readiness will assist practitioners choose the appropriate time to introduce projects, determine availability of the required skills and resources in the community to implement the project, and identify areas for specific areas requiring

facilitation and development. Determining the state of readiness of a community may also provide insight into what steps may be necessary to increase the readiness of a community prior to introduction and implementation of a health promotion project. Using a participatory research design should be considered in such a context, which would facilitate increasing community capacity.

3. Community need identification and assessment, and process and outcome evaluation tools that are easily understood, administered, and analyzed by community members in community development/Healthy Community project contexts would provide health promotion practitioners with a method to further facilitate the process of enabling individuals and groups to influence the health of their community. The identification of a lack of formalized approaches to both need identification/assessment and evaluation in this study may limit the impact of efforts that groups organized under the premise of the Healthy Communities concept. Such tools may also provide vital information and data that could legitimize community development/Healthy Communities projects in the eyes of the gate-keepers who control resources, and regional health authorities considering implementing such projects. Here again, a participatory approach to this research may be most beneficial for all stakeholders.

4. Understanding that the Regional Health Authority was the primary facilitator and organizer of the project in this context, health promotion practitioners need a sound understanding of organizational development theories and practices and small group behaviors, particularly at the community level, and in the health promotion context. Dissemination of current theories and research findings regarding organization and small group theories in the health promotion context would also help practitioners

understand the processes community based organizations go thorough while attempting to influence their environment to improve health. Such insight may also provide practitioners the ability to apply specific facilitation skills in order to assist these groups overcome the barriers and challenges prevalent in grass roots community organization/small group setting.

5. This study demonstrated the willingness and activities groups organized under the Healthy Communities banner undertake to influence healthy public policy. Health promotion practitioners and researchers require an understanding of public policy development processes. Both research into the processes involved in the development of healthy public policy, and the skills required to influence and advocate for healthy public policy at the community level will assist practitioners in facilitating and enabling individuals and communities to advocate for policies that provide a supportive environment required to influence the factors that affect both an individual's and a community's health.

Footnotes

[1]Although the original WHO concept was known as Healthy Cities, the term "cities" was viewed as too exclusionary in Canada as many municipalities do not consider themselves to be a city, there was a need to develop parallel projects in smaller sections of cities in Canada, and health promotion efforts in Canada focused on community mobilization (Hancock, 1993a). Therefore, for the purposes of this discussion, further references to healthy community and healthy communities will be considered equal to healthy city and healthy cities respectively.

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Appendix A: Recruitment Letter and Reply Form

[Date]

Dear [Coalition] Member,

You are invited to take part in the research project 'The Process of Creating a Healthy Community in Rural Alberta'. Brett Hodson is conducting this project for his thesis research at the University of Alberta. Part of the evaluation project is being funded through Alberta Health and the Health Transition Fund.

This research is being carried out to help understand the process of creating a healthy community. It is hoped that this study will assist the [Coalition], other Healthy Community projects, and health promotion practitioners and researchers to understand the process of creating a healthy community.

If you are over 18 years of age, and have attended at least two coalition meetings in the past year, you are eligible to participate in this study. Participation involves being interviewed a maximum of two times, for at total time commitment of one and a half to two and a half hours. The Health Research Ethics Board at the University of Alberta has approved this study.

If you are **not** interested in being contacted about participating in this study, please fill out the attached form, seal it in the stamped envelope provided, and place it in the mail. Your reply will be mailed directly to Brett Hodson. Two weeks from now, Brett Hodson will contact you by telephone if you have not returned the attached form to set up a date and time to explain the study in greater detail. You will then have the opportunity to decide if you would like to consent to participate in the study. If you have any further questions about this study please do not hesitate to contact Brett Hodson at 255-0241.

Best regards,

_____
[Signed],
[Coalition Co-Chair]

_____
[Signed],
[Coalition Co-Chair]

Reply Form: The Process of Creating a Healthy Community in Rural Alberta

Investigator: Brett Hodson, BPE
MSc, Health Promotion Student
16 Haysboro Crescent S.W.
Calgary, Alberta, T2V 3E9
Ph#: (403) 255-0241
E-mail: bhodson@cadvision.com

Please complete and return in the postage paid envelope provided.

____ (please check) **No**, I do not wish to be contacted about participating in this study.

Name _____

Signature _____ Date _____

Appendix B: Information Sheet

Information Sheet

Research Title: **The Process of Creating a Healthy Community in Rural Alberta**

Investigator: Brett Hodson, BPE
MSc, Health Promotion Student
16 Haysboro Crescent S.W.
Calgary, Alberta, T2V 3E9
Ph#: (403) 255-0241
E-mail: bhodson@cadvision.com

Thesis Supervisor: Kim Travers, Ph.D.
Associate Professor
Centre for Health Promotion Studies
5-10 University Extension Building
University of Alberta
Edmonton, Alberta, T6G 2G3
Ph#: (403) 492-9415
E-mail: ktravers@afns.ualberta.ca

PURPOSE

The purpose of this research study is to understand and evaluate the process used by a health coalition in rural Alberta to create a healthy community.

PROCEDURE

1. The researcher will ask you to describe your experiences with the community health coalition. The interview will last about one to one and a half-hours.

2. The discussion will be tape-recorded. Only the researcher and the person writing out the tapes will listen to the tapes.

3. The tapes will be written out. The researcher and the thesis supervisor will read the written copy of the tapes.

4. Anything that could be used to identify you, including your name and the names of others, will be erased from the written copy of the tapes.

5. You will be given a written copy of the tapes to review. The researcher will ask you if the written copy is correct. If anything is unclear, a second interview may be requested. The second interview, if requested, will be about one hour long.

PARTICIPATION

There are no known risks to you if you take part in this study. Results of this study may help the health coalition, health professionals, individual community members and other communities better understand the process of creating a healthy community.

You do not have to be in this study if you do not wish to be. If you decide to be in this study you may drop out at anytime by telling the researcher. You do not have to answer any questions or discuss any subject in the interview, or at any other time, if you do not want to. The co-chairs of the health coalition will not be informed of who did and who did not participate in this study. Your name will not appear in this study. A code number will be used instead of your name, and will appear on any forms or question sheets. Your name, and the names of others, will be erased from the written copy of the tapes. We may publish or present the information and findings of this study in journals or at conferences, but your name or any material that may identify you will

not be used. As stated by University Policy all tapes, written copies of the tapes, and notes will be stored in a locked cabinet separate from consent forms and code lists for at least seven (7) years after the research has been completed. Consent forms will be kept in a locked cabinet for at least five (5) years. Data may be used for another study in the future, if the researcher receives approval from the appropriate ethics review committee.

If you have any questions about this study at this or any other time, you can call the researcher or his supervisor at the numbers above.

If you have any concerns about any part of this study, or how the study is being conducted, you may contact [Regional Contact] at the [Regional Health Authority] at [phone number]. Alternatively, you may also contact Dr. Gerry Glassford, Graduate Coordinator at the University of Alberta Centre for Health Promotion Studies at (403) 492-9347. [Regional Contact] and Dr. Glassford are not directly involved in this research study.

I, the research participant, have reviewed this information letter with the investigator and I understand its contents.

_____ _____

Initials of Research Participant Date

_____

Printed Name

I, the investigator, have reviewed this information letter with the research participant.

_____ _____

Initials of Investigator Date

_____

Printed Name

REQUEST FOR SUMMARY:

If you wish to receive a summary of the study when it is finished, please complete the next section:

Name: _____

Address: _____

_____

_____

Appendix C: Consent Form

CONSENT FORM

Part 1 (to be completed by the Principal Investigator):

Title of Project: **The Process of Creating a Healthy Community in Rural Alberta**

Principal Investigator(s): Brett Hodson, Graduate Student

Co-Investigator(s): Dr. Kim Travers
Centre for Health Promotion Studies, University of Alberta (403) 492-9415

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your participation in the coalition.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to the information you provide?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____	_____	_____
Printed Name	Date	Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator or Designee	Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Appendix D: Interview Guide

Interview Guide

Grand Tour Question

I am very interested to learn about the community health coalition, can you tell me about experiences as a member of it?

Potential Probes/Guiding Questions

Can you describe for me…

What does the coalition do to determine the health needs of the community?

How the coalition makes decisions?

What does the coalition do to prioritize health concerns of the community?

What is the role of the Regional Health Authority in the community health coalition?

What is the role of the local municipality in the community health coalition?

You mentioned…could you please tell me more about that?

When you say…how do you define that?